hours after death. Page 6 may be retained by the hospital or attending physician.	ertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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3. REGISTRAR'S SIGNATURE

Davelson-Randall

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (THEM 27) (Type, Print,

RICHARD

NOV 2 9 1994

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH Kenneth Walker III 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH WALKER SR. 111 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7/1910 1 M 2 - F 220-12-8418 YRS. Maryland 9a. FACILITY NAME (If not institution, give 9b. CITY. TOWN OR LOCATION OF DEATH 9c. ÇOUNTY OF DEATH 2538 Parack Harford Harford Falleton Fallston RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Harford Fallston 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2538 Pocock Road 21047 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried 3 Widowed 4 Divorced Specify: Caucasian 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Black & Decker Tools 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Walker George Edward Sr. Emma Houck 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Luray Walker #10 as 20a. METHOD OPOISPOSITION
1 Burlel 2 ACCEMENT 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE cemetery, cremetory or other plece)
Carroll Cremation 11/25 4 Donation 5 Other (Specify) Hampstead. Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland lun 23. PART I. Enter the diseases, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause of each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition autonosefenta Jackenrascular Desenie reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE DF). that initiated events reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL: YES 2 NO OTHER: 1 | Inpetient 2 | ER/Outpetient 3 | DOA 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigat Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner ea stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. Delanger 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME and, Middle, Las	Ä Ellen	WI	LSO	N	2. DATE OF DEATH DAY	94		S'. 30P
	235 64 7991			IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year)	C	ountry)	CE (State or Foreig
	9a. FACILITY NAME (If not institution, giv			h CITY TOWN (OR LOCATION OF DE	June 9, 19	9c. COUNTY		lvania
DIRECTOR	CHURCH +	HOSPITAL			TIMOR	-	JC COOKITY		
<u> </u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COU	NTY	10c, CITY,	TOWN OR LOCAT	TION			104	. INSIDE CITY
E	MD	Baltimore		Ra 1	timore				LIMITS?
AL	10e. STREET AND NUMBER	Dalelmole			I. ZIP CODE		10g. CITIZEN		
# 1	435 53rd. St.				2	21224		USA	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 VES IF YES, GIVE WAR OR	3 2 X NO	If yes, sp		NIC ORIGIN? (Specify Yee on, Puerto Rican, atc.)		RACE — / Black, Wh Specify:	American Indian Indian White
	15. DECEDENT'S E	DUCATION	16a. DECEDENT'S US	SUAL OCCUPATION	ON	16b. KIND OF BUSI	NESS/INDUST	RY	WILLE
1	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind at wor life. Do NOT use i	rk done during mo retired.)	ist of working				
MP	2nd	100 100	H	ousewif	e	Hot	me		
COMPL	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden S	Sumame)		+ 1
BE	Leonard	Renner			Flore			_	nknown
2	190. INFORMANT'S NAME (Type/Print)					Route Number, City or Town,			
	Mary A. Collins			_		ore, Maryla			
	t Suriel 2 Cremetion 3 R	smovsi from State	bb. PLACE AND DATE OF emetery, crematory or othe	or plece)		OATE 20c. LOC			
	21. SIGNATURE OF FUNERAL SERVICE	The same of the sa	arrett Co.		ND ADDRESS OF FA	11/13 Oak	land, I	Mary	<u> </u>
	12. M.	Carllo C			rt Funer				
	23. PART I. Enter the diseases, o	- Willian				St., Oaklan		21	550
ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF:	tion		monia			day
0	PART II. Other significant condit	ions contributing to death	but not resulting in	the underlyin	g cause given in	Part I. 24a. WAS AN A	AUTOPSY	24b. WEI	RE AUTOPSY FIN
MEDICAL						PERFORM 1 YES 21	MED?	CON OF	ILABLE PRIOR T APLETION OF CA DEATH?
AN: N									
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQŞPITAL:		26. PI	LACE OF DEATH (Ch	eck only one)			
> 1	t 🗆 YES 2 🗇 🗘	1 postlent 2 ER/Ou	rtpatient 3 🗆 DOA 4		ne 5 🗆 Residence	6 Cother (Specify)			
ВУ РН	27. MANNER OF OEATH 1 X Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		RY WC	URY AT ORK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURE	0	
	3 Suicide 8 Could not in determined	building, atc. (So	RY — At home, farm, streecify)	eet, factory, offic	a	281. LOCATION (Street as City or Town, Stete)	nd Number or Ri	ural Route	Number,
MPLET		YSICIAN: To the bast of my kno	wledge, death occurred	at the time, date	and place, and due	to the cause(e) and mann	ner as stated.		
COM	one) 2 MEDICAL EXAM	INER: On the basis of examinet	ion and/or investigation,	In my opinion, o	leath occured at the	time, date end place, end	due to the cer	use(e) end	l manner se ste
ш	29b. SIGNATURE AND TITLE OF CERTIF	4			29c, LICENSE NUI		29d. DATE SIG		
TO B	Elias 1	Abboud to	1.0		12435	35	> //	19	194
-	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF D	DEATH (ITEM 27) (Type, P		, ,	.10	3D a 1 =	imar	o MD
	31. DATE FILED (Month, Day, Year)	A DOUV &	NATURE .	Chi	arch 15	espital	, balt	riilor	e, MD
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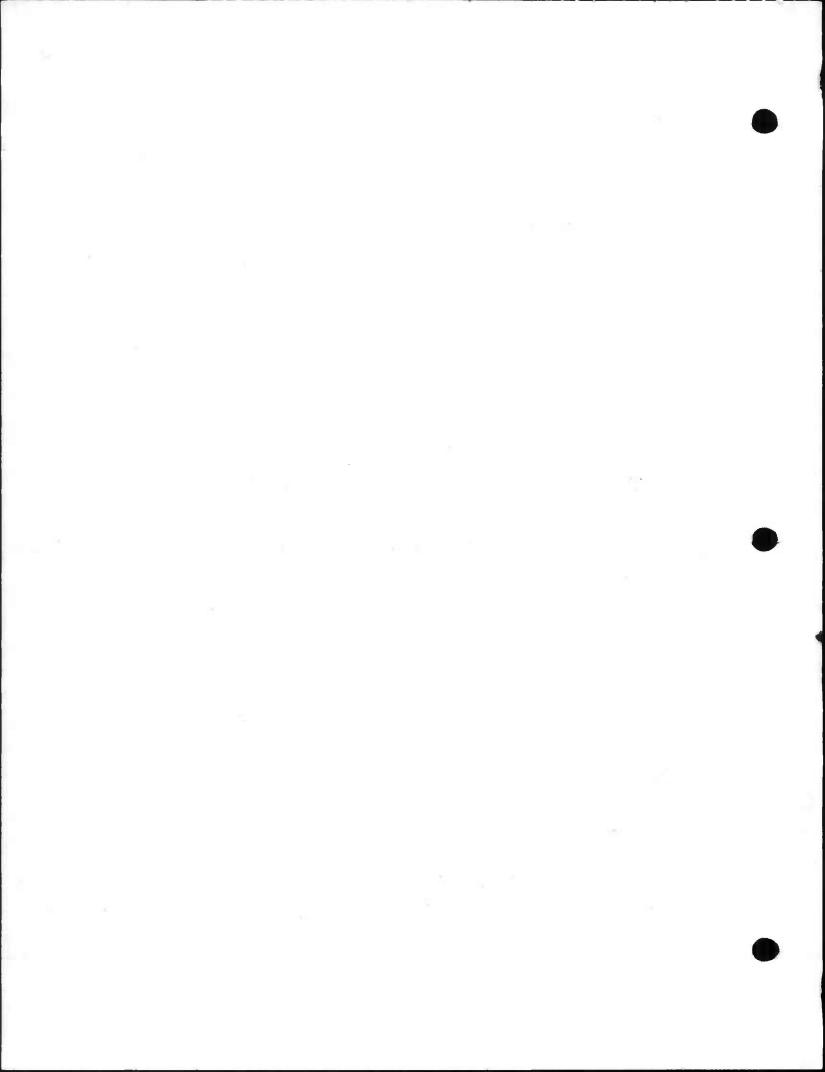
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with nounce after death. Page 6 may be retained by the hospital or attending to	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the 1	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
OR ATTENDING	JIRECTOR: After	ours after deat	em 28 is ma
SPITAL (INERAL D	thin 72 he	NT: It it
TO THE HO	TO THE FL	be filed wi	IMPORTA

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH NOVEMBER ESTER 0025 A H 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs, last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 262-52-8222 57 DAYS HOURS MIN. 135 M 2 New York YRS Sept. 19, 193 ga. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Rockville Montgomery Shady Grove Adventist Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Gaithersburg Maryland Montgomery 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 24001 Sugar Cane Lane American 20882 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES В Specify White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done during most of working life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) Broadcasting 12 Journalist 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sum-Brewer Lester Eugene Woodruff Gerturde A . BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Jown, Signa, Zip Code) 20882. 24001 Sugar Cane Lane, Gaithersburg, Md. 2 Sheila Sylvester 20e, METHOD OF DISPOSITION
1 N Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Davis Cemetery of other place) 21/ Davis, West Va. 5/ Other (Specify) 22. NAME AND ADDRESS OF FACILITY
Olin J. Molesworth, P.A., Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Villiams When L. 26401 Ridge Rd., Damascus, Maryland 23. PART / Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, ehock, or heart failure. List only one cause on eech line. Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** diseese or condition Acuto MYOCARDIAL resulting in desth) DUE TO (OR AS A CONSEQUENCE OF HUDBRTENSI DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): 405RY CAUSE (Diseese or injury thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? YES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN 🛛 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — Af home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the fime, date end place, and due to the cause(s) and manner ea stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTERED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 1994 9 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) WAYNE FRIESTPY) MediCAL 31. DATE FILED (Month, Day, Year) lis d'avelier



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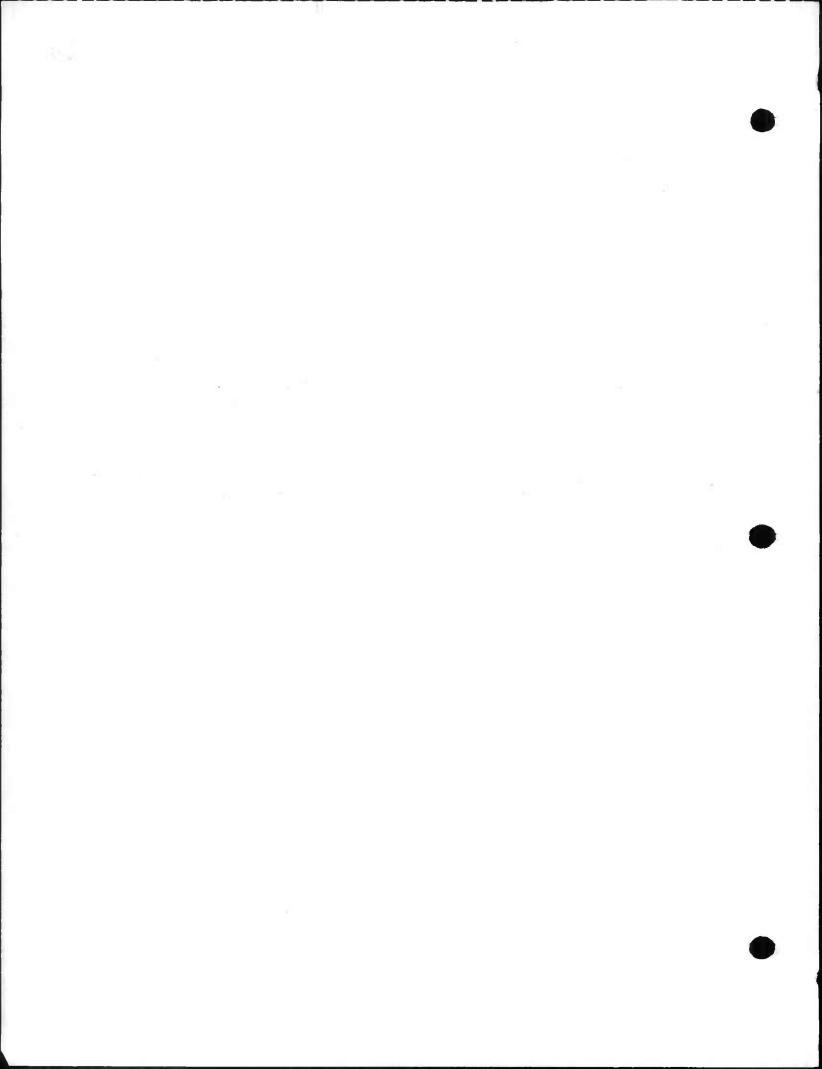
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ²20, 1994 Grace WEDUM November 6:50 pm Mildred 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Oct 25,1906 DAYS HOURS 1 M 2 F 88 YRS. 526-09-2096 0klahoma 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Homewood Retirement Center Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 TYPES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 205 West College Terrace 21701 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Maxican, Puerto Rican, etc.) Specify: White BY 1 TYES 2 X NO Specify. 3 Wildowed 4 Divorced ED 18a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S FOUCATION 18b. KINO OF BUSINESS/INOUSTRY (Specify only high COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) ĕ George **EVANS** Asa Clementina GARDNER 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joyce Alaine Scott 4934 North 35th Street, Arlington, Virginia 22207 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must emetery, cremetory or other plece)
Smithsburg Crematory 11/22/94 Smithsburg, Maryland the medical examiner 21. SIGNATURE OF JUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home vell Kobersen MOO706 106 East Church St, Frederick, MD 21701 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ehock, or heart fellure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition resulting in death) arterios strati event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST Injury, PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO. PHYSICIAN: UNCERTAIN [23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate in the State in the State in HOSPITAL: OTHER: 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Rursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 2ad. OEȘCRIBE HOW INJURY OCCUREO 28 is marked, Natural 5 Pending 1 YES 2 NO ВУ Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — Al home, ferm, streel, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide determined Item 29e. CERTIFIER 1/ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end menner as stated. (Check only one) FUNERAL within 72 I TO THE HOSPITA
TO THE FUNERAL
BE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) BE D09689 November 21,1994 9 30. NAME AND ADDRESS OF PEASON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

300 West Ninth Street, Frederick, Maryland 21701

M.S.

32. REGISTRARYS SIGNATURE
JULYA WRULLON Reveall

Austin Pearre NOV 2 3 1994



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

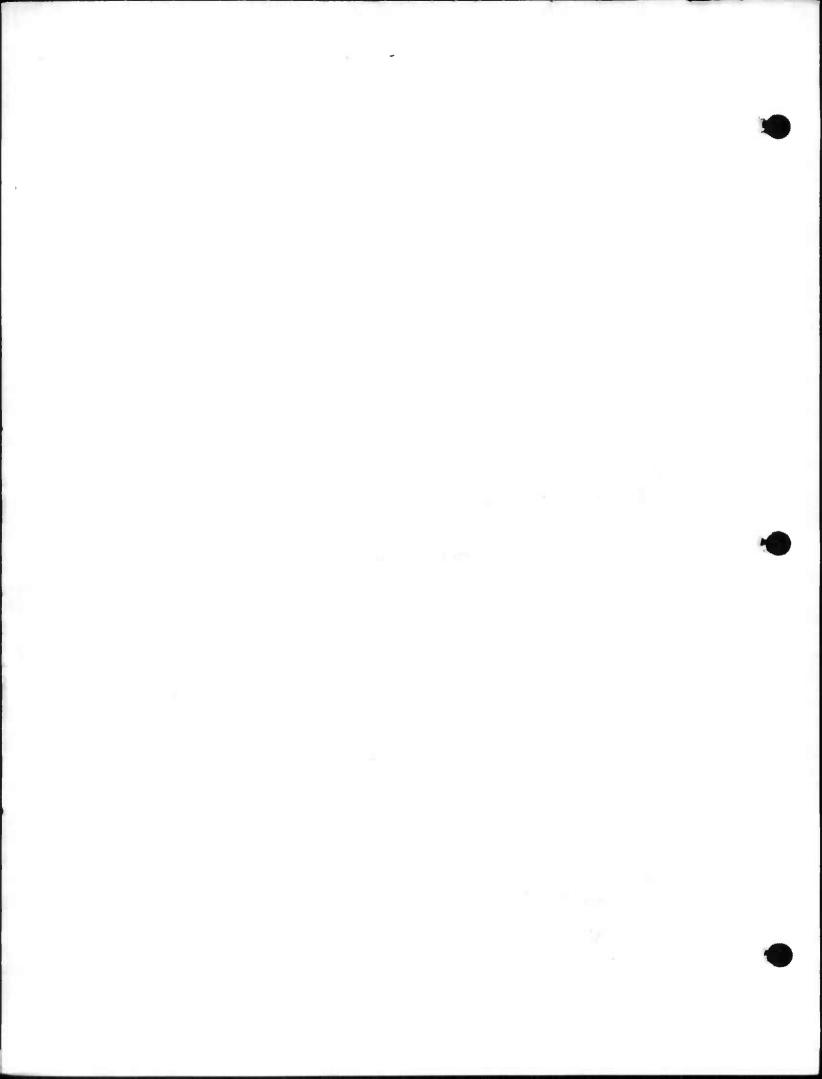
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
		Harr	V		1	Wise					Nov. 1		994	2:45 a M
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. las		IF UNDER			R 24 HRS.	7. DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign
		230-09-624	6	1 Am 2 - F	91	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 9-14-03		Count	irginia
		Be. FACILITY NAME (If not in							R LOCAT	ION OF DE	ATH		NTY OF D	
	9	Easton Memo		ospital			Easton					Talbot		
	ᇤᅵ	RESIDENCE OF DEC	10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION					10d, INSIDE CITY
	DIRECTOR	Maryland	Caro	line		_	nton							LIMITS?
- 1	_	10e. STREET AND NUMBER						101	ZIP COE	DE		10g. CIT	IZEN OF Y	WHAT COUNTRY?
	FUNERAL	Camp Road	and C	olonial	Drive				216	529			USA	
	5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AP	MED					IC ORIGIN? (Specify Yes	or No-	14. RACI	E — American Indian, k, White, etc.
	BY	1 Never Married 2 3 Vidowed 4 Divo		IF YES, GIVE V	YES 2 TI	••			2 X NO		n, Puerto Ricen, etc.)			* Black
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			y higheat grade		(G	ive kind of a	vork done d	uring mo	st of work	ing	IND. KIND OF BUS	HINE 33/IN	DUSTRY	
	COMPLET	3rd	, ,	College (I-4 or 5	" La	bore	r				Farming			
once	Š	17. FATHER'S NAME (First, M									ME (First, Middle, Maiden	Sumame)		
te p	BE	Luther Wi								Jena	Smith			
_=	2	Ruth Virgi		ice	19						Newark, N.			
t be		20a. METHOD OF DISPOSIT	ION		20b. PLACE	AND DATE	OF DISPOSI					CATION —		
mus		1-□ Burial 2 □ Crematic 4 □ Donation 5 □ Other		oval from State	Sprir			"ome	tars	7	11/19/94 D	anto	n M	d
iner		21. SIGNATURE OF FUNERA	L SERVICE LIC	PHOSE.			22.1	AME AN	ID ADDRÍ	ESS OF FAC	CILITY		11.9 11	
ехап		1		1							., Easton,			
dicai		23. PART i. Enter the d	Seesee, or o	omplications the	t caused the de	ath. Do r	not enter	the mo	de of dy	ing, auch	Funeral H	ratory ar	reet,	Approximete
E		IMMEDIATE CAUSE (Fir		List only one ceu	•									interval Between Onset and Death
t,		diseese or condition	→		later.		In	ev.	m o	nia				5dais
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natic	N O	Sequentielly liet conditi		DUE TO	OR AS A CONSE	UENCE O	VALM	UT	VI					LWEEKS
traur	EA	if any, leading to imme- cause. Enter UNDERLY	ING	100	vebr	al	Int	2a-	ct	w	ith Let	7		54 cars
ther	ERTIFICATION	CAUSE (Disease or injuthat initiated events	· 1	DUE TO	(OR AS A CONSE	DUENCE DI	F):		-			,		
, 00	Ä	resulting in death) LAS	' L.	1	en.	0-1	51	5	_					
ulen,	C	PART II. Other eignifice	nt condition	s contributing to	deeth but not i	eeulting	in the un	deriying	ceuse	given in l	Pert i. 24s. WAS AN		24b	. WERE AUTOPSY FINDINGS
any	MEDICAL	- Con	gest	ive	Hear	+	1-	ail	UVR		PERFOR	-		AWAILABLE PRIOR TO COMPLETION OF CAUSE
OWS	ME		J											OF DEATH? 1 YES 2 NO
23 sh	z	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 N	10 [UN	CERTAIN	10			
E C	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	28. PLAC	E OF DEAT	H (Check o							
or Item	<u>s</u>	1 VES 2 NO		1 12 Inpatient 2			4 🗆 Nurs	Ing Home		asidenca	6 Other (Specify)			
	PHY	1 Natural 5	Pending	28a. DATE OF (Month, D		28b, TIM INJ	E OF URY M		URY AT RK? 'ES 2 [NO.	28d. DESCRIBE HOW II	NURY OC	CURED	
	D BY	2 Contains	Investigation Could not be	28e. PLACE O	F INJURY — At ho	me, farm, s	Itreet, facto			-	281. LOCATION (Street a	nd Number	r or Rural I	Route Number,
28			datarmined	building,	atc. (Specify)						City or Town, State)			
을 2	Ĭ										to the cause(s) and man			
IMPORTANT: II	COMP.			: On the basis of a	camination and/or	investigatio	n, In my op	olnion, de	eath occu	red at the t	time, data and place, and	due to th	ne cause(s	s) and manner as stated.
P ORI		296. SIGNATURE AND TITLE	OF CERTIFIER	20	10				29c. LIC	ENSE NUM	BER 7/2	29d. DAT	E SIGNED	(Month, Day, Year)
₹ 3	5	30. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CAIR	SE OF DEATH (ITE	M 27) /3m-	Print)		D	TL	160	P (1/1.	7/74
		TIMOTH	1	DEX	INEN	Tari (1900)	00	D	UTC	HM	ANS L	ANE	E	ASTOW MD
		31. DATE FILED (Month, Day.	Year)		R'S SIGNATURE	-	,		J . w					
		NOV 17	1994	J-nardi	widson-Ra	ndell						_		

the magnitude of attending projectall.	detached for use as the burial-transit permit. Pages 1, 2, 3 should		0000
The rest of the second of the	1	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

			*				4 30300
1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, List)	MAY WI	ISON					3. TIME OF DEATH
220-10-6424	1 🗆 M 2 🗹 F		F UNDER 1 YEAR DAYS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6.	BIRTHPLACE (State or Foreign Country) MARY land
9a. FACILITY NAME (If not inetitution, give stre			b. CITY, TOWN C Center	R LOCATION OF DE		9c. COUNTY	OF DEATH
Maryland Queer	n Annes		sonvil	_e			10d. INSIDE CITY LIMITS? 1 YES 2 NO
1133 Perry Corner			10f	21638		USA	OF WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	U.S. ARMEO 2 X NO TES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: 12 YES 2 NO Specify: 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Yes or No—If yes or No—If yes, specify Yes or No—If yes or No—If yes, specify Yes or No—If				
15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of won life. Do NOT use n	k done during mo: etired.)	N st of working	16b. KIND OF BU	siness/indus	
17. FATNER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden		
Augusta Lee 19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	ODRESS (Street a		ett Askins Houte Number, City or Tow	n, State, Zip Co	de)
Charles D. Wilson 20a. METHOD OF DISPOSITION 12 Burlet 2 Cremetton 3 Remov	20b.	1133 P	DISPOSITION /Na		OATE 20c.LC	CATION — City	or Town, Stata
21. SIGNITURE OF FUNERAL SERVICE LICE	NSEE , WOO	odLawn Ce	Benr	o address of fa nie Smith	Funeral	Home	n, Ma.
23. PART I. Enter the diseases, or co shock, or heart failure. Li iMMEDIATE CAUSE (Final disease or condition resulting in death)	ist only one cause on as	tha death, Do not ch line.	antar tha mo	ta of dying, such	,	iratory arrast	Approximata interval Betwee Onset and Daa
Sequentially list conditions, if any, lasding to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
PART II. Other significant conditions UTT	contributing to death bu	t not resulting in t	tha underlying	cause given in	Part I, 24a. WAS AN PERFOI	RMEO?	24b. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF OEATH (Che	ick only one)		1 PES 2 NO
- A	HOSPITAL: 1 Inpatient 2 ER/Outpe	tlant 3 DOA 4		-	6 Other (Specify)		
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 1 YES 2 PAO 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 PAO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Month, Day, Vear) 29b. TIME OF Sec. INJURY AT WORK? M 1 YES 2 NO 26d. DESCRIBE HOW INJURY OCCUREO							EO
3 Suicide 6 Could not be detarmined	26a. PLACE OF INJURY - building, etc. (Specif	— At home, farm, atra	et, factory, office		28f. LOCATION (Street City or Town, State)	and Number or F	Rural Route Number,
	AN: To the best of my knowle						use(a) and manner as stated.
29b. SIGNATURE AND TULE OF CERTIFIER	~			29c. LICENSE NUM			GNEO (Month, Day, Year)
30. NAME AND ADDRESS OF SERSON WHO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Pri	Ples.	مار رو	ma 1	11.15	
NOV 10 1994	32. REGISTRAR'S SIGNA		1 120		, ,))	50-1	

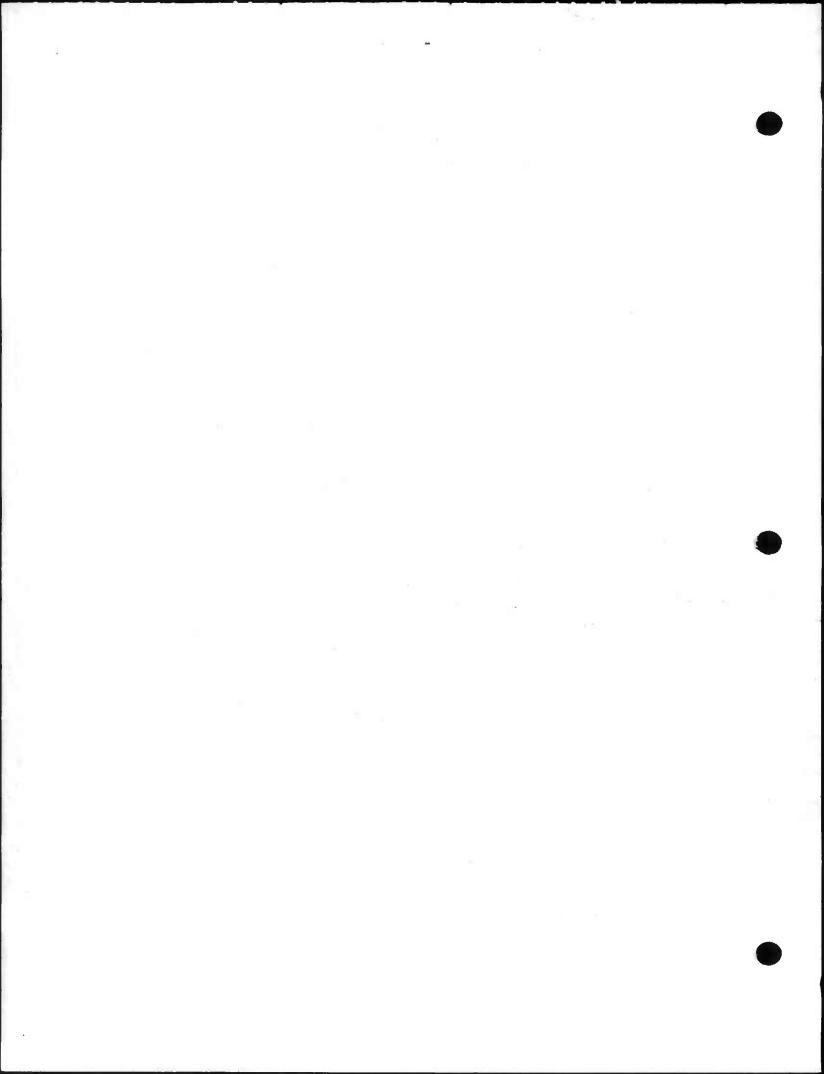


ined by the hospital or attending physician. could be detached for use as the burial-transit permit. Pages 1, 2, 3 should MARYLAND 21215-0020

0 DIVISION OF VITAL BECORDS

BALLIMONE, MANYLAND	ter death. Page 6 may be retained by the hosp	the funeral director, page 5 should be detache	wal.	al examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 687601	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

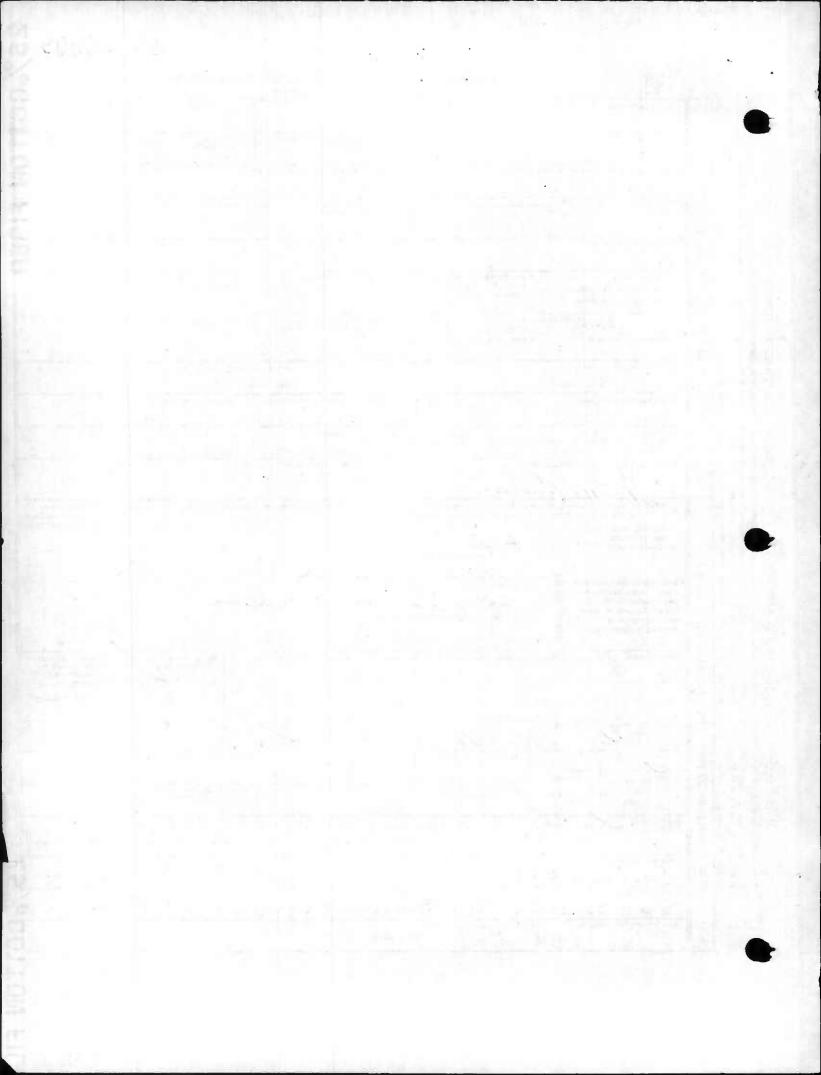
	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTAL HYGIEN	_	
	1. DECEOENT'S NAME (First, Middle, Las	it)			2. DATE OF DEATH	YEAR	3. TIME OF DEATH
		loward	Wright		Nov 23		10:37P M
	4. SOCIAL SECURITY NUMBER		MC	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTH Count	IPLACE (State or Foreign
	219-07-7981		34 YRS.		Oct.10.1		MD
8	9e. FACILITY NAME (If not institution, giv			CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY OF D	
DIRECTOR	Memorial Ho	<u>spital @ Ea:</u>	ston	Easton		Talbo	ot
RE	10e. STATE 10b. COU			OWN OR LOCATION			10d, INSIDE CITY LIMITS?
		roline	F∈	ederalsburg			1 - YES 2 NO
RAI	100. STREET AND NUMBER	ademy Avenue		101. ZIP CODE		10g. CITIZEN OF V	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II		21632	NIC ODICING (CII-V	US	
4	1 Never Merried 2 X Merried	FORCES? 1 YES	2X NO	It yes, specify Cuban, Mexic	en, Puerto Ricen, atc.)	Black	E — American Indien, k, White, atc.
ВУ	3 Widowed 4 Divorced			1 TYES 2 NO Speci		эрес	"y White
COMPLETED	15. DECEDENT'S El (Specify only highest gra	DUCATION rde completed)	18e. DECEDENT'S US (Give kind of work	done during most of working	16b. KIND OF BUS	SINESS/INDUSTRY	
=	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Service	operator	Gas Pr	onano	
OM	17. FATHER'S NAME (First, Middle, Last)	U	-		AME (First, Middle, Meiden		
BE C	Frank Wrigh	it		Mae	Roe	our individual in the control of the	
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	ORESS (Street and Number or Rural	1,00	n, State, Zip Code)	*
F	Mildred G. Wri	ght	611 /	cademy Aven	Federa	Isburg.	Md.21632
1 1	20e, METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Re	amovat from State 20b	PLACE AND DATE OF	ISPOSITION (Name of	DATE 20c. LO	CATION - City or To	wn, Stata
	4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE		oncord	remetery No		Federal	sburg,MD.
	A SUNTAL SERVICE	MOENSEE		Williamson		Home	
\square	(Your			Federalsbur	ra. MD. 2	1632	
	23. PART I. Enter the diseesea, o shock, or heert fallur	er complications that caused e. List only one cause on a	the death. Do not ach line.	enter the mode of dying, aud	ch aa cerdlec or reepl	ratory arrest,	Approximate Intervel Between
	IMMEDIATE CAUSE (Finel disease or condition	111.75					Onset and Death
1 1	resulting in death)	OUE TO (OR AS A	CONSEQUENCE OF):	LUYZB			KIWK
z		- MYPERICAL			IC ASCITE	5	1
일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):				
윤	cause. Enter UNDERLYING CAUSE (Disease or Injury	c. ACIDOSIS	CONSEQUENCE OF:	F. CARDI	AC CIRRH	0515	
CERTIFICATION	thet initieted eventa resulting in death) LAST	a COR PUL		9. STASIS	S ULCERS	S	j
	DADT II. Other significant as a dist						
SAL	PART II. Other significent conditi	one contributing to death b	ut not resulting in t	he underlying ceuee given in	Pert I. 24s, WAS AN PERFOR		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC					1 TYES 2	□ NO	OF DEATH?
Σ	DID TOBACCO USE CON	ITPIRITE TO CAUSE O	E DEATH VEC	☑ NO ☐ UNCERTAI			1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	4	28. PLACE OF GEATH (N L		
Sic	EXAMINER?	HOSPITAL:		THER: Nursing Home 5 Reeldenca	6 Other (Specify)		
PHYSICIAN:	27. MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJURY AT WORK?	26d, OESCRIBE HOW II	JURY OCCUREO	
₽	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO			
요	3 Suicide 8 Could not b	28a. PLACE OF INJURY building, etc. (Spec	— At home, term, stree cify)	et, tectory, offica	281. LOCATION (Street e City or Yown, State)	nd Number or Rural F	loute Number,
	29e. CERTIFIER						
COMPLET				t the time, date end place, end dus n my opinion, death occured at the) end manner ee stated.
BE	296. SUGNETSLINE AND TITLE OF CENTER	del de	~	29c. LICENSE NU	MBER	29d. DATE SIGNED	
2	30. NAME AND ADDRESS OF PERSON V	VHO COMPLETED CASSE OF DE	ATH (ITEM 27) (Type, Pri	nt)		., 0	/ / /
	403 MARVEZ		N MD	21601			
	31. DATE FILED (Month, Day, Year) 1994	32 MEGISTRAR'S SIGN.	ATURE				
	MAA 50 1991	0	1				



			1 - STATE STATE O	F MARYLAND / DEPA CERTII	RTMENT OF HEAL		NTAL HYGIENE		
			1. DECEDENT'S HAME (First, Middle, Last)				DATE OF DEATH	YEA	
			Randolph F 4. SOCIAL SECURITY NUMBER 5. SEX	Wilkerson 6. AGE (In yrs. last birthday)) IF UNDER I YEAR IF U	INDER 24 HRS. 7,	11/ 22 DATE OF BIRTH	100	4 8:45 A M
	pin		213-24-0814 1 🛣 M 2 🗆		MONTHS DAYS HOU	IRS MIN.	(Month, Pay 3 ar) 23	3 N	ew Church, Va
	2, 3 should	DIRECTOR	213-24-0814 Hill	JAJZ BIOW	95. CITY, TOWN OR LO			Worce	
	es 1,	EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUHTY	10c. C	ITY, TOWN OR LOCATION				10d. IHSIOE CITY
	permit. Pages	1 1	Md. Worceste	r	Snow H				LIMITS?
		RA	5492 Snow Hill Road		10f. ZIP (CODE		10g. CITIZEH (OF WHAT COUNTRY?
Cian	burial-transit	FUNERAL		EDENT EVER IN U.S. ARMED		863	RIGIN? (Specify Yea o	II . 9	RACE — American Indian.
215-0020	the buria	BY FI	1 Never Married 2X XMarried FORCES?	1 YES 2 THO		Cuban, Maxican, Pu			Black, White, etc. Specify:
215	USE as	ED	15. DECEDENT'S EDUCATION		'S USUAL OCCUPATION		16b. KIND OF BUSIL	HESS/INDUSTR	white
21	o o	ET	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	life On NOT	f work done during most of w use retired.)	vorking			
The hospital	ched es	COMPL	11	Farmi	ng/Agricu]	lture	Own Fa	rm	
Y a	be detached	8	17. FATHER'S NAME (First, Middle, Last)		16. R	MOTHER'S NAME (First, Middle, Maiden Su	imame)	
R W		BE	LLovd F. Wilkerson 19a. IHFORMAHT'S HAME (Type/Print)				Mae Wilk		
MARYLAND retained by the hospit	5 should notified	2			AODRESS (Street and Nui				
m &	page page		Hazel Wilkerson 20a. METHOD OF OISPOSITION	5 / O	8 Whiton I	Road		TION - City o	
ORE 6 may	must		1 XBurlal 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify)	cemetery, cremetory or	other plece)		20		
Page -	funeral director,		21. SIGHATURE OF FUHERAL SERVICE LICENSEE	Bates Co	22. HAMÉ ANO AO	ORESS OF FACILIT	1/ 16 S	now H	ill,Md.
BALTIMORE, after death. Page 6 may be			Vatricia L. L	lenns					Hill, Md.
SO. with	pletely fille cremation, rent, the	L	23. PART I. Enter the diseesea, or complications ehock, or heert failure. List only one IMMEDIATE CAUSE (Finel diseese or condition resulting in death)	thet ceused the death. Do ceuse on each line. May be to constant the ceuse of the					Approximate Interval Between Onset and Death
P.O. BOX 687	ending physician and co Hygiene prior to buria or other traumatto	ERTIFICATION	Sequentielly list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	E TO (OR AS A COHSEQUENCE OF TO (OR AS A COHSEQU	OF):				
DS, the de	Mer	2	PART II. Other eignificent conditions contributing	g to death but not resulting	in the underlying ceu	se given in Part			24b. WERE AUTOPSY FIHDINGS
RECOR	8 E E	MEDICA					PERFORMI		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 HO
₹ 8	as Depl	A	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL			NCERTAIN []		
F aff	State 1	SICIAN:	EXAMINER? HOSPITAL	:	ATH (Check only one) OTHER:				
F <	the the	PHYS		2 ER/Outpetient 3 DOA E OF IHJURY 28b. Til	4 Nursing Home 5 C		Other (Specify)	Umy occuper	
O F	fter this eath with marked	N N	1 X Natural 5 Pending (Mon		IJURY WORK?		. DESCRIBE HOW INJ	ORY OCCURE	,
O SMICE	. After r death Is ma	ВУ	2 Accident Investigation 3 Suicide B Could not be 28s. PLA	CE OF IHJURY — At home, term,			LOCATION (Street and	Number or Ru	rai Route Number
DIVISION OF VITA OR ATTENDING PHYSICIAN: The	DIRECTOR: hours after item 28 la	ETED	4 Homicide detarmined	ling, atc. (Specify)			City or Town, State)		Total Harrison,
_ 4	7 P =	COMPL	(Check only one)						
IOSPI	FUNERAL within 72 t	8	2 MEDICAL EXAMINER: On the basia	of axamination and/or investigat	ion, in my opinion, death o	ccured at the time,	, data and place, and o	due to the cau	ee(a) and manner as stated.
TO THE HOSPITAL	포를	H .	296. SIGHATORE AND TITLE OF CERTIFIER	Lmich, ME	29c.	D 153	84	Md. OATE SIGN	18D (Month, Day, Year) 23 94
		OT	RODNEY A.	CAUSE OF DEATH (ITEM 27) (Typ)		ER ST.	SALIS	SBURY	md. 21801
		0	31. DATE FILED (Month, Day, Year) NOV 23 1994	STRAR'S SIGNATURE					

	ğ
1	
4	
2	3
100	executed
1	8
5	N: The law requires that the death certificate be executed w
L .	death
5	the
	that
O U	requires
3	ME
1	The
1 1	SICIAN:
)	PH
TOTAL OF ALIAL RECORDS, P.O. BOX 00100	ATTENDING PHYSICIAN: The

4. SOCIAL SECURITY NUMBER 218-26-4023 1		1. DECEDENT'S NAME (First,		"lovel	W:II-						2. DATE OF E	DAY	YE	AR	IME OF DEATN
THE PART OF THE PA		William				4		* VF40	er touren	04.1000	11	10			11:00 P
14110 Caine Stable RD									-		(Month, De	y. Year)		Country)	
### ### ### ### ### ### ### ### ### ##				7.	04	_	9b. CITY	TOWN C	OR LOCATIO	ON OF DEA					D
MD Worcester Ocean City WILLIAMS STABLE AND NUMBER 14 10 Caine Stable Road 14 11 Caine Stable Road 15 CANTER AND NUMBER 15 CANTER AND NUMBER 15 CANTER AND NUMBER 15 CANTER AND NUMBER 16 CANTER AND NUMBER 16 CANTER AND NUMBER 17 CANTER AND NUMBER 18 CANTER AND SOCIETY 18 CAN	H.														
MD Worcester Ocean City ### ATTECT AND NUMBER 14 10 Caine Stable Road	5	RESIDENCE OF DEC	EDENT				00	carr	City				WOI	ceste	r
THE STREET AND IMARIES 14110 Caine Stable Road 11. MARTAL STRUE 12. WAS DECERDET STRIP IN U.S. AMBED 13. WAS DECERDET OF HIBMAND CONDIGHT (Speetly was on No.— 14. RACKE — American Indies, speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which, with the speedly Color, Marcian, Party No. 20. No. 15. RACKE — American Indies, which is a speedly color, Marcian, Party No. 20. RACKE — American Indies, which is a speedly color, Marcian, Party No. 20. RACKE — American Indies, which is a speedly color, Marcian, Party No. 20. RACKE — American Indies, which is a speedly color, Marcian, Party No. 20. RACKE — American Indies, which is a speedly color, Marcian, Party No. 20. RACKE — American Indies, which is a speedly color, Marcian Indies, which is a speedly color, Marcian Indies, which is a speedly color, Marcian Indies, which is a speedly color of the speedly of which does not not indies. While is a speedly color of the speedly color of the speedly color, Marcian Indies, which is a speedly color of the speedly	RE					10c, CI1	Y, TOWN C	R LOCAT	TION					10d.	
Security			Wor	cester		00	cean	-							•
Second Decrease F ves, gark with on arise 1	RAI		Chala	I- DI								100			COUNTRY?
Security	N.		e Stab		IT EVED IN II S	ADMED	142				0010110 00				
Burnal Countries	0	1 Never Married 2 🔀		FORCES?	YES 2	□ NO		f yes, sp	ecify Cube	n, Mexican,					
Elementary/Recordary (8-12) Cottinge (1-4 or 5 -) Restaurant Owner Food Service					164					107	16b. KIN	ID OF BUSINES	S/INDUST	RY	
WITHIAM F. WITHEY, Sr. 19. MALING ADDRESS (Street and Number or Rural Route Number of the Street) 19. MALING ADDRESS (Street and Number or Rural Route Number of the Street) 19. MALING ADDRESS (Street and Number or Rural Route Number of the Street) 19. MALING ADDRESS (Street and Number or Rural Route Number of the Street) 19. MALING ADDRESS (Street and Number or Rural Route Number of the Street) 19. MALING ADDRESS (Street and Number or Rural Route Number of the Street) 19. MALING ADDRESS (Street and Number of Rural Route Number of	1				+)	life. Do NOT u	se retired.)						0		
WITHIAM F. WITLEY, Sr. 196. MALING ADDRESS (Street and Number or Rural Route Number of the Route Number of the Ruse Number of Rural Route Numbe	IM I			4		Rest	aurai	it C	_					/ice	
The MALING ADDRESS (Street and Number or Rural Route Number, City or Rown, Striet, 20 Code) Patricia Rozell 403 Williams St. Berlin, Md. 21811 10 Entitle of St. Street St. S				v Sr									ame)		
Patricia Rozell 403 Williams St. Berlin, Md. 21811 200, NETROG OF DISPOSITION 11 Berlin 2 (XCrewatton 3 Removal from State 41 Donation 5 Other (Specify) 21. SIGNATURE OF FURNESS. SERVICE LICENSES 22. PART II. Donation 5 Disposition Dispositio	0			,, 511			ADDRESS	. (0						4-1	
20. METHOD OF DISPOSITION 20. DEATH 20c. LOCATION - City or Town, State 20c. DOCATION - City or Town, State 20c. DOCATION - City or Town, State 20c. LOCATION - City or Town, State 20c. L	2													,,	
Burdia 2 Committee Cape Cap					20b. PL 4					berni	-			or Town.	State
22. SIGNATURE OF SUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 2181 23. PART II. Enter the diseases, or complications that covered the death. Do not enter the mode of dying, such as cerdisc or respiratory strest, inches the facility of the cause on each line. 108 Williams St. Berlin, MD 2181 23. PART II. Enter the diseases, or complications that covered the death. Do not enter the mode of dying, such as cerdisc or respiratory strest. 108 Williams St. Berlin, MD 2181 24. PART II. Order algorithm of the stress of the s				oval from State	cemeteo	ape H	en lor	en	Cren	itory	11/1	1 Fra			
Burpage Funeral Home Berlin, MD 2181 23. PRET I. Enter the diseased, or complications that coused the death. Do not enter the mode of dying, such as cerdisc or reepiratory streat, whole, or heart failure. List only(give cause on each line. IMMEDIATE CAUSE (Final idease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): A. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): A. DUE TO (O		21. SIGNATUME OF FUNERUL	L SERVICE LIC	ZENSEE			22.	NAME AN	ND ADDRE	SS OF FACI	LITY	1			
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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

29b. SIGNATURE AND TITLE OF CERTIFIED

TJORNER

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100 Power

32. REGISTRAR'S SIGNATURE

hi Daviden-Rondall

William

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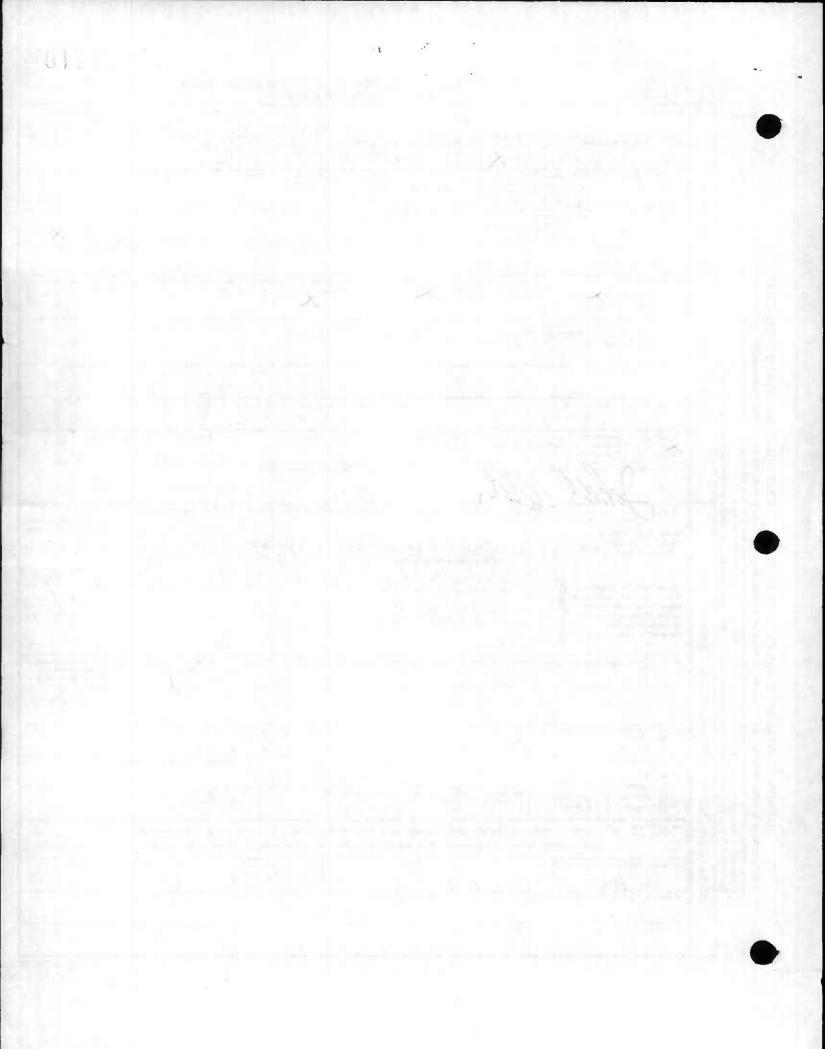
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	nit. Page	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Flours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Page to the within 72 hours after death with the State Dest. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
e executed within nours after	an and completely filled in by the r to burial, cremation, or remove	umatic event, the medical
equires that the death certificate b	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the further sited within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal.	tows any injury, or other tra
TENDING PHYSICIAN: The law re	TOR: After this certificate has bee after death with the State Deot. o	28 is marked, or item 23 st
TO THE HOSPITAL OR A	TO THE FUNERAL DIRECT D	IMPORTANT: If Item

94 36510 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR BETTYE COSTELLO 1820 oods 101994 November 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS 219-16-3020 HOURS 1 M 2 KF 69 12-1-24 MD 9a. FACILITY NAME (If not institution, give street and number, Sc. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD WORCESTER OCEAN CITY 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 0355 KEYSER POINT RD 21842 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 166. KIND OF BUSINESS/INDUSTRY dery (0-12) College (1-4 or 5+) EDUCATION 12 TEACHER 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) UNKNOWN MARY COSTELLO LACROIX BE 19a. INFORMANT'S NAME (Type/Print) 2 JOHN J. WOODS KEYSER POINT RD OCEAN CITY, 2184 MD., 20a METNOD OF DISPOSITION
134 Burlel 2 Cremation 3 Rei 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State BERLIN 21. SIGNATURE ON FUNERAL SERVICE DICENSES ULLRICH FUNERAL HOME BERLIN MD. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdlec or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final disesse or condition vero resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury enous DUE TO (OR AS A CONSEQUENCE OF) thet initisted events resulting in deeth) LAST PART ii. Other aignificent conditions contributing to dasth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE PHYSICIAN: MEDICAL 1 TES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Pinperient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigatio 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

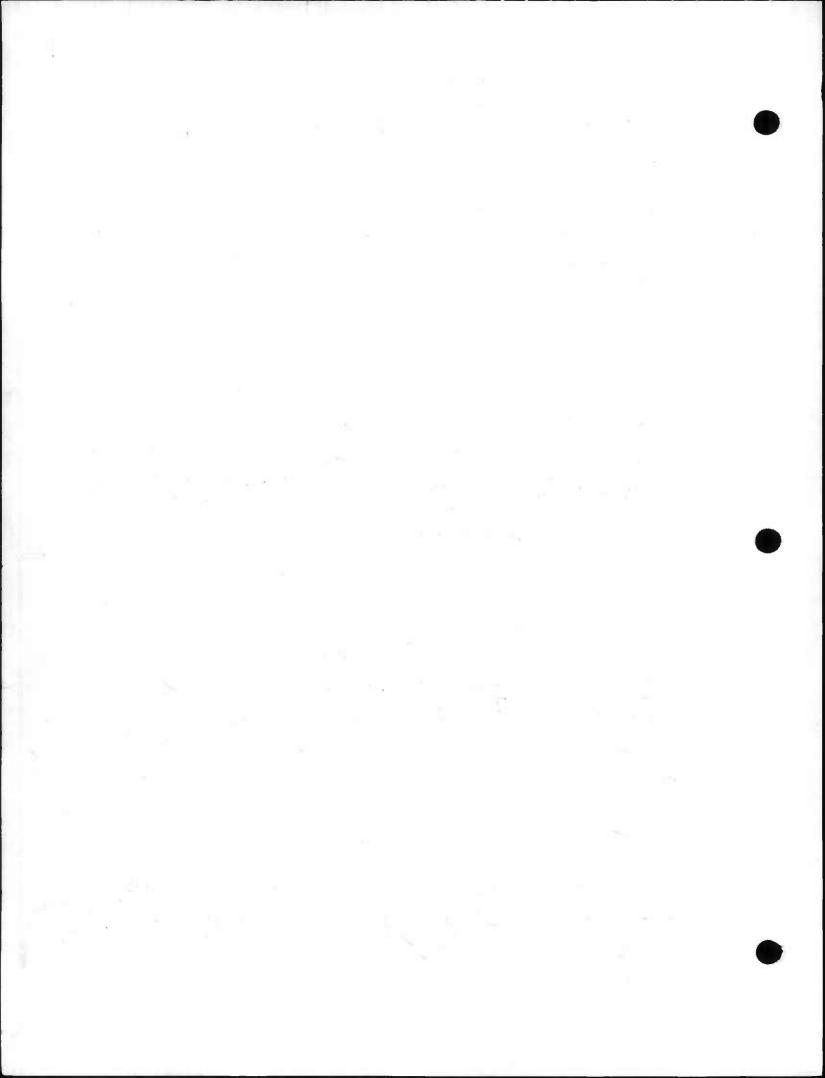
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 13653 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)



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STATE OF MARY	LAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG NO

	1. DECEDENT'S NAME (First, Middle, Last)	William Richa	rd Your	CATE OF	DEATH	REG. NO.	12	TIME OF DEATH
	willia,	weckedin Necha	na Joune	JOHN	6	MONTH DAY	/ YEAR	2:35pm
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLA	CE (State or Foreign
	705-10-2753	1 12 M 2 D F 89	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 09/22/1905	Woodst	ock, MD
Or.	Sa. FACILITY NAME (If not institution, give :	street and number)			OR LOCATION OF DE	EATH 9c	C. COUNTY OF DEAT	
DIRECTOR	508 6th Avenue			Brunswe	LCK		Frederi	.ck
BEC	10e. STATE 10b. COUNT			, TOWN OR LOCA			100	I. INSIDE CITY LIMITS?
	Maryland Frede	enick		3 munswic				YES 2 NO
FUNERAL	508 6th Avenue			10	21716	10	g. CITIZEN OF WHAT USA	COUNTRY?
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	J.S. ARMED	13. WAS DE		IIC ORIGIN? (Specify Yes or I	No - 14. RACE -	American Indian,
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			pecify Cuben, Mexice S 2 NO Specify	n, Puerto Rican, etc.)	Black, Wi Specify:	White
	15. DECEDENT'S EDU	ICATION 1	80. DECEDENT'S U	ISUAL OCCUPATI	ON	16b. KIND OF BUSINE		WALLE
ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)		ork done during me		IOD. KIND OF BUSINE	:35/MD051R1	
COMPLETED	7		Laborer			B&O RR		
00	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden Sum	name)	
BE	Frank Young 190. INFORMANT'S NAME (Typo/Print)		10h MAII INC	ADDRESS (Street	Anna Ch	naney Poute Number, City or Town, St		
2	Carrie K. Young		508 6	th Avenu	ue. Bruns	wick, MD 21%	716	
	20e. METHOD OF DISPOSITION 1 **Buriel 2 ** Cremetion 3 ** Ren	20b. P	LACE AND DATEO	F DISPOSITION /N	leme of		ION — City or Town,	State
	4 Donation 5 Dother (Specify)	Pa	ery, cremetory or other heigh	hts Ceme	etery /	1/26 Brun	swick. Mi)
	21. SIGNATURE OF FUNERAL SERVICE LI	4.1.1 11/a	Pa .	John	ND ADDRESS OF FA	ams Funeral Le Rd., Bri	Home	
- 1	Banbana H. Wi	lliams, Owner		100 9	Petersvil	Le Rd., Bri	unswick,	MD 2171
	23. PART I. Enter the diseases, or shock, or heert fellure.	complicatione that caused t	the death. Do no th line.	ot enter the mo	ode of dying, suc	h es cerdiec or reepirato	ory arreet,	Approximate Interval Betw
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	resulting in deeth)	DUE TO (OR AS AC	Sistemanic of	-				24
Z	Sequentielly list conditions,	b						
CATION	If any, leading to immediate cause. Enter UNDERLYING	OUE TO (DR AS A C	ONSEQUENCE OF):				
임	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS A C	ONSEQUENCE OF):				
ERTIFI	resulting in death) LAST	d						
AL C	PART II. Other significant condition	ns contributing to death but	not resulting in	the underlyin	g cause given in	Part I. 24s. WAS AN AUT	TOPSY 24b. WE	RE AUTOPSY FINO
EDICA	Chronic	rand	Peil	400		PERFORMED	O? AM	ILABLE PRIOR TO MPLETION OF CAU OEATH?
W	Bleedin	y dupage	en]	4/10	R		or or	YES 2 NO
AN	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	77.77	YES NO			
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	LACE OF DEATH (Ch			
PHYS	1 YES 100	1 ☐ Inpetient 2 ☐ ER/Outpeti	28b. TIME	4 Nursing Hor	JURY AT	8 Other (Specify) 28d. DE\$CRIBE HOW INJUI	RY OCCURED	
ВУ Р	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		ORK? YES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJURY — building, etc. (Specify	At home, term, at	treet, tectory, offic	CO CO	281. LOCATION (Street end I City or Town, State)	Number or Rural Route	Number,
	4 Homicide determined							
ETE	290. CERTIFIER	IICIAN: To the best of my knowled	ige, death occurred	d at the time, date	e end place, and due	to the cause(s) end menner	as stated.	
E	(Check only CERTIFYING PHYS					time, data end place, end du	us to the cause(s) en	d
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BE COMPLET	(Check only 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIE	ER: On the basis of examination e	end/or investigation	7)	29c. LICENSE NUM		d. DATE SIGNED (MO	
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BE COMPLET	29b. SIGNATURE AND TITLE OF CERTIFIE	ER: On the besis of examination of	zim	か				



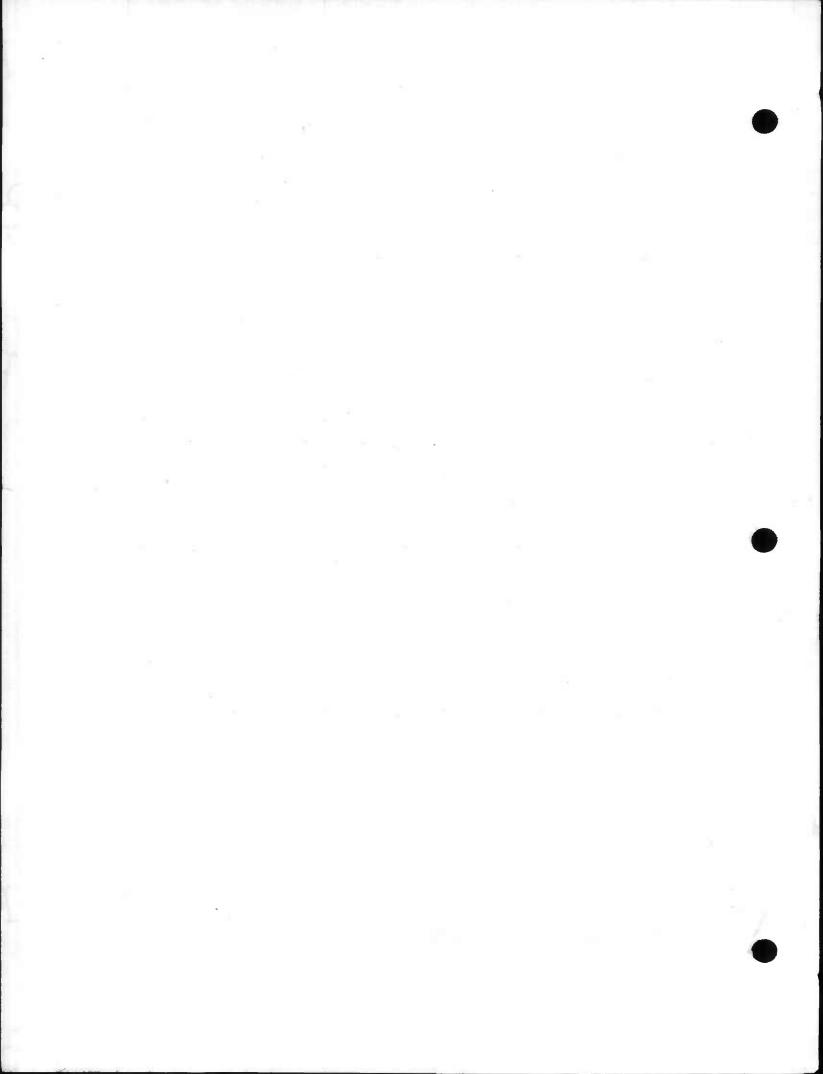
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32 MEGISTRAR'S SONATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. OECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF OEATH YEAR 8.30 DM 12 Willie E. Atkinson
4. SOCIAL SECURITY NUMBER 5. S 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS 19729/34 N. C. 237-52-6708 1 X M 2 - F 60 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR VAMC FORT HOWARD Fort Howard, MD 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTO 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2636 OSWEGO AVE 21215 U.S,A use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES If yes, specify Cuben, Maxican, Puerto Rican, etc.)

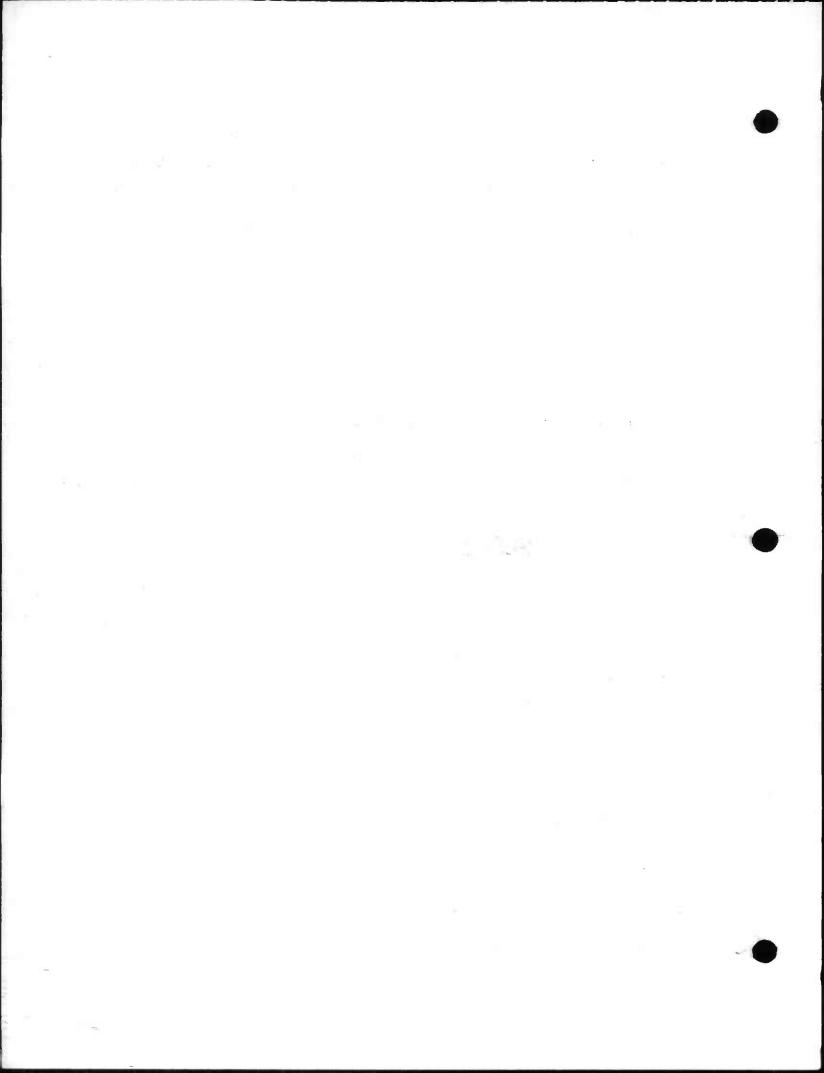
142 YES 2 NO Specify: 1 Never Married 2 Married BY Specify: 3 Widowed 4 N Divorced BLACK ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12TH CAR MECHANIC once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) SAMUEL ATKINSON TINA COBBS BE notified funeral director, page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FANNIE WOODARD 2636 OSWEGO AVE BALTO, MD 21215 Pe 90 20e. METHOD OF DISPOSITION
1 K Burlel 2 Cremetion 3 Removal from State Page 6 may 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must CKENGMENORIAL PK 121094 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNOUNE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY death. MARCH f/H-WEST 4300 WABSH AVE executed with cours after day and completely filled in by the to burial, cremation, or removal. medical 23. PART J. Enter the elesses, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, shock, or heart fallure. Liet pniy one cause on each lina. Approximate intervai Between **Onset and Death IMMEDIATE CAUSE (Finel** the disease or condition Carcinoma Of Oropharynx reaulting in death) event, OUE TO (OR AS A CONSEQUENCE OF): traumatic Cachexia CERTIFICATION Sequentially liet conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata been signed by the attending physician it, of Health and Mental Hygiene prior to certificate be Diabetes Mellitus cause. Enter UNDERLYING CAUSE (Diseese Dr injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 0 Injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAII ARLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ICIAN: has be Dept. MP 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate that the State HOSPITAL: 1 YES 2 NO ATTENDING PHYSICIAN: PHYSI 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28b. TIME OF INJURY 28e. DATE OF INJURY 28c. INJURY AT WORK? this co 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO After 1 BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 90 ETED. 8 Could not be DIRECTOR: A 4 Homicide 28 datermined tem OR 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. COMPL TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) end manner es atated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D-18298 Augustin lugar 6/94 mD 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AUGUSTIN 9600 North Point Rd. Fort Howard, MD 2152



JISTON OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF I	HEALTH AND	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			. TIME OF DEATH
	TYRONE E.	RNEST	ANDE	RSOM	/	NOV :	78 9	YEAR /	INDOA H
			yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		s. BIRTHPL Country)	ACE (State or Foreign
	219-70-1418 9a. FACILITY NAME (If not institution, give stree	1 ⊠ M 2 □ F 3	2 YRS.	MONTHS DAYS	HOURS MIN.	Sept. 1	-	Mary	yland
DIRECTOR	Deaton Specialty Ho				Ltimore		9c. COUNT	TY OF DEA	
2	10e, STATE 10b, COUNTY		100 CITY	TOWN OR LOCA	TION				
E	Maryland		100.011		imore C:	i			0d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				f. ZIP CODE	ıty	100 CITIZ		AT COUNTRY?
FUNERAL	1000 Druid Hill	Avenue			212	01	log. Ciriz	USA	AI COONTAIT
S		2. WAS DECEDENT EVER IN		13. WAS DEG		NIC ORIGIN? (Specify)	fes or No—	14. RACE -	- American Indian,
	1 Never Married 2 Married	FORCES? 1 YES			ecity Cuben, Maxica 2 ANO Specif	in, Puarto Rican, etc.)		Black, 1 Specify:	White, etc.
Э ВУ	3 Wildowed 4 Divorced							-	Black
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	rion mpleted)	(Give kind of w	ork done durina mi	ON ost of working	16b, KIND OF B	USINESS/INDU	STRY	
J.E	Elementary/Secondary (0-12)	Coflege (1-4 or 5+)	iife. Do NOT use	,	TT l		D 1		
OMI	17. FATHER'S NAME (First, Middle, Last)		r a	ctory	Worker	ME (First, Middle, Maid	Fact	ory	
	Alfred Buie					an Ander			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or To		Codel	
2	Lillian Andersor	n			11 Ave.				1
	20a, METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remove	206.	PLACE AND DATE OF	DISPOSITION (N.			OCATION — C		
	4 Donation 5 Other (Specify)		tery, cremetory or oth butus Ce	meterv	12/	02/94 Ba	ltimor	e Ci	tv. MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE //	2	22. NAME A	ND ADDRESS OF FA				
	> Suc the	owell				MD 2120		• IVOLT	LII AVE.
	23. PART I. Enter the diseases, or con	mplicatione that caused	the death. Do no					at,	Approximate
	shock, or heart fellure. Lie IMMEDIATE CAUSE (Finel	ot Dnly one cause on ee	ch line.						Interval Between Onset and Death
	disease or condition resulting in death)	AIDS							3mos.
- 1	0.000	DUE TO (OR AS A	CONSEQUENCE OF	:					
N	Sequentially list conditions,								
ATI	If any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF)	:					
임	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)	:					-
CERTIFICATION	reaulting in deeth) LAST								
	PART II. Other aignificant conditions of	contributing to death but	t not regulation in	the underlyin	a cause chies la	Part I as una	IN AUTOPSY	T	ERE AUTOPSY FINDINGS
CAL	Pressur-uleers	to death bu	t not resulting in	die underlym	g cease given in	PERF	ORMED?	A	VAILABLE PRIOR TO OMPLETION OF CAUSE
	Cerebrovaseular	akteries				1 YES	2 NO	0	F DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE		DEATH VE	ПИОГ] UNCERTAIN			1	☐ YES 2 → NO
¥	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH		JONCERIAII	10			
SIC	EXAMINER?	108PITAL:		OTHER:	ne 5 🗍 Rasidence	8 Other (Specify)			
并	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c, IN.	URY AT	28d. DESCRIBE HOW	/ INJURY OCCU	JRED	
BY F	1 Natural 5 Pending 2 Accident Investigation	(mond), Day, roal)	1830		YES 2 NO				
	3 Suicide 6 Could not be	28s. PLACE OF INJURY - building, atc. (Specif	At home, farm, st	reet, factory, offic	a	28f. LOCATION (Stree City or Town, Stat	et and Number o	r Rural Rou	te Number,
	4 Homicide determined								
PP		N: To the best of my knowle							
COMPLETED	2 MEDICAL EXAMINER:	On the besis of examination	and/or investigation	, in my opinion, o	leath occured at the	time, data and placa,	and dua to the	cause(s) a	nd manner as stated.
BE (296. SIGNATURE AND TITEE OF CERTIFIER	6.0			29c. LICENSE NUM	MBER	29d. DATE	SIGNED (N	Ionth, Day, Year)
0	surpleter 1.				D1485	08	NO	729	1,1994
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, I	3. 1/2		that is	2-		
	31. DATE FLED (Month, Day, Your)	32. REGISTRAR'S SIGNAL	חומב שוע	nemo	wed, 1	hd. 212	_50		
	DEC 0 9 1994 41	Dhucker Rand							
	U 1007 XW	TO SUMMERSON STEERS	all.						



ITEMS: 10e, 10f, PER F.H. FILM G-718 12/9/94 t.t

1	-	FOR STATE REGISTR	AR
1	. D	ECEDENT'S	NA

	1 - FOR STATE REGISTRAR	STATE OF I		/ DEPART				MENT	AL HYGIEN	E		
ŀ	1. DECEDENT'S NAME (First, Middle, Last) Sean A.		**					MON	TE OF DEATH		YEAR	3. TIME OF DEATH
9	Sean A. 4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER	YEAR EU	NDER 24 HRS.	De	C 04	199		PLACE (State or Foreign
	217-90-3228	1 🛛 📈 2 🗆 F	19		MONTHS	DAYS HOU		API	R. I, 19	75	MARYI	AND
OR	90. FACILITY NAME (If not institution, give st 201 N. Streene RESIDENCE OF DECEDENT		2+			altin		HTA		9c. COUN	n/a	EATH
<u>[</u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			Inc CITY		R LOCATION						10d. INSIDE CITY
DIRECTOR	MARYLAND	n/a		100. 0111,	BA	LTIMO	RE					LIMITS?
FUNERAL	100. STREET AND NUMBER 828 N. STREET	R STRE	E.			10f. ZIP	21210	5 21	.205	UNI		STATES
BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 X		It.	AS DECENDE yes, specify (Luben, Mexica	n, Puert	ilN? (Specify Yes o Rican, etc.)	or No-	Black	
B	15. DECEDENT'S EDUC (Specify only highest grade	CATION	18a.	DECEDENT'S U	SUAL OC	CUPATION		-10	56. KIND OF BUS	INESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of wo ille. Do NOT use CASHIE	retired.)	_			V	'AR I OL	US	
	17. FATHER'S NAME (First, MIDDIN, Last) JAMES BROWN			0.101112		-		ME (First	, Middle, Maiden HEARD	Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)	-		195 MAILING	nnpess	/Street and Also			mber, City or Tow	- Paste Vie	0-4-1	
2	JAMES BROWN/BARBA	ARA HEAR	D									AND # 05
	20a, METHOD OF DISPOSITION \$\frac{1}{2}\Burlet 2 \subseteq \text{Cremetion } 3 \subseteq \text{Remotion} 4 \subseteq \text{Donation} 5 \subseteq \text{Other} \left(\text{Donation} \right) \subseteq \text{Characteristics}	oval from State		IMORE			Y 1			TIMO		vn, Stata MARYLAND
	21. SIGNATURE OF PUNERAL SERVICE LIC	ENSEE CA	and a		22. N	IAME AND AD	DRESS OF FA		-1101	E. NO	ORTH	AVENUE
	23. PART I. Entar the diseases, or c shock, or heart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cau	t caused that ise on each life (dR AS A CONS	na.				han ca	rdisc or reapi	ratory arre	eat,	Approximata interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	D	(OR AS A CONS									
SAL S	PART II. Other eignificant condition	a contributing to	death but no	t reaulting in	the unc	derlying cau	ae givan in	Part i.	24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDI	DID TOBACCO USE CONTR	DIDLITE TO CA	USE OF DE	ATLL VE			LCEPTA II					1 VES 2 INO
A	25. WAS CASE REFERRED TO MEDICAL	GBOTE TO CA		ACE OF DEATH			NCERTAIN	ч Ц				
YSIC	EXAMINER?	HOSPITAL:			OTHER		Residence	X ott	ner (Specify) a	t sc	ene	
_	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, D	INJURY lay, Year)	28b. TIME INJU		28c. INJURY A WORK?	1 NO	28d. D	ESCRIBE HOW I	VUURY OCC	URED	
B	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At	home, ferm, str	reet, facto		2 10 110	281. LC	CATION (Street a	nd Number	or Bural B	oute Number A &
ETED	4 Homicide determined	buliding,	otc. (Spocify)	ET					y or Town, State) N. STRE	tief-	50	BATTING RE
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINET											and manner as stated
	doe INCHATURE AND TITLE OF CENTURES		1						- end prece, dit			
O BE	July AY	1	LM			29c.	LICENSE NUM	71	F	29d. DATE		(Month, Day, Year)
24	MARIO F EOU	COMPLETED ON	25.0			C.L.						05 1994
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE	TIT PO	enn	stre	et, B	alt	Imore	. Ma	ryl	and 21201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

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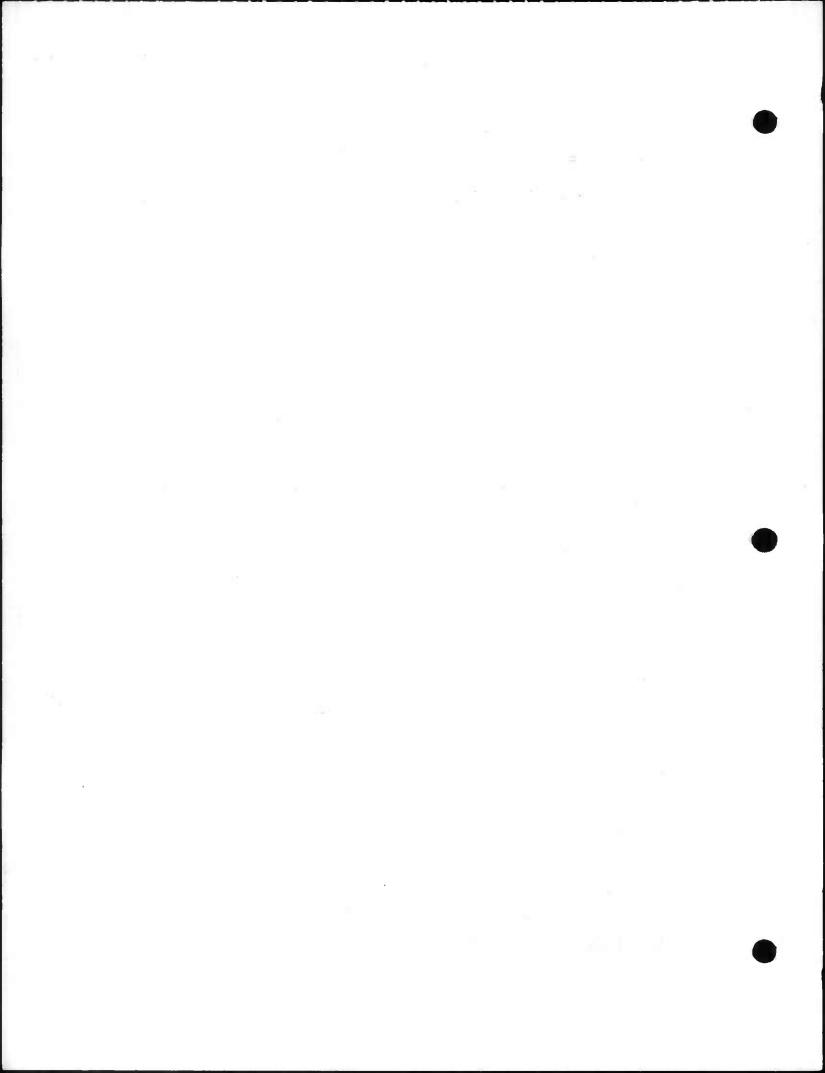
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician.
ite has been signed by the attendi
the fleet within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremotal.
IMPORTANT: Il tiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	ITEM: 4. PER F.H. FILM G-718 12	/9/94 t.t				
	1 - STATE OF M	ARYLAND / DEPARTI CERTIFIC	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH
	Jessie Beatrice Bran	nch		DECEMBER	05 1994	
			F UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8, BIR	THPLACE (State or Foreign
	217-20- 91332 1 M 2 XXF	O/ YRS.	ONTHS DAYS HOURS MIN.	MAY 23, 1		E"ARUNDEL, MD
œ	· ·		b. CITY, TOWN OR LOCATION OF D		9c. COUNTY OF	
Ē	Union Memorial Hosp	ital	Baltimore (City		n/a
<u> </u>	10e. STATE 10b. COUNTY	10c. CITY, 1	OWN OR LOCATION			10d, INSIDE CITY
L DIRECTOR	MARYLAND n/a		BALTIMORE			1 YES 2 NO
FUNERAL	3214 AVON AVENUE		101. ZIP CODE 2121	.8	UNITED	STATES
5	F000F00 4 /	EVER IN U.S. ARMED YES 2 X NO	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14. RA	CE — American Indian,
B	1 Never Married 2 Married IF YES, GIVE WILL A Wildowed 4 Divorced	R OR DATES	If yes, specify Cuben, Mexic 1 YES 2 XIO Speci		Sp	eck, White, etc. BLACK
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S US	UAL OCCUPATION	16b. KIND OF BUS	SINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (8-12) College (1-4 or 5+) GRADE SCHOOL -	We. Do NOT use n	k done during most of working effect.) ESTIC	(in ow	n home)
	17. FATHER'S NAME (First, Middle, Last) ROBERT PINDELL		18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	,
띪				RRIE BROWN		
2	190. INFORMANT'S NAME (Type/Print) PAULINE KNIGHT	3214 /	AVON AVENUE,	BALTIMORE,	n, State, Zip Code) MD @ 2	1218
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF		DATE 20c. LO	CATION — City or	Town, State
	1 Surial 2 Cremation 3 Removal from State	ASBURY UNI	PED METHODIST (EM.12-9 GL	EN BURN	IE. MD
	21. SIGNATURE OF UNERAL SERVICE LICENSEE	//	22. NAME AND ADDRESS OF FA			
	· Vanena Co	e/	WM. C. MARCH			TH AVENUE
ļ	23. PART I. Enter the diseases, or complications that shock, or heart fallure. List only one caus	caused the death. Do not	anter the mode of dying, suc	h as cardiac or reapi	ratory arrest,	Approximata
	IMMEDIATE CAUSE (Final	o bit each line.				Interval Between
1						Onaet and Death
ļ		EPSIS				i .
	disease or condition a. 50 DUE TO (c	OR AS A CONSEQUENCE OF):				12 hrs.
NO	disease or condition resulting in death) a	OR AS A CONSEQUENCE OF): POGLYCEMIC	SEIZURE V	IS EINCEPI	HALOPAT	12 hrs.
ATION	disease or condition resulting in death) a. DUE TO (Sequentially list conditions, b. DUE TO (If any leading to immediate	POGLYCEMIC OR AS A CONSEQUENCE OF):				12 hrs.
FICATION	disease or condition resulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OR AS A CONSEQUENCE OF): POGLYCEMIC OR AS A CONSEQUENCE OF): HBLE HEPATO	SEIZURE V			12 hrs.
TIFICATION	disease or condition reaulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	OR AS A CONSEQUENCE OF): POGLYCEMIC OR AS A CONSEQUENCE OF): HBLE HEPATO OR AS A CONSEQUENCE OF):	CELLULAR C			12 hrs. 12 hrs. 2 months
CERTIFICATION	disease or condition reaulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	OR AS A CONSEQUENCE OF): POGLYCEMIC OR AS A CONSEQUENCE OF): HBLE HEPATO	CELLULAR C			12 hrs.
AL CERTIFICATION	disease or condition reaulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	OR AS A CONSEQUENCE OF): POGLYCEMIC OR AS A CONSEQUENCE OF): HBLE HEPATC OR AS A CONSEQUENCE OF): COHOL ABUSE	CEWULAR C	Part I. 24s. WAS AN	AUTOPSY 2	12 hrs. 12 hrs. 2 months Several yis 4b. WERE AUTOPSY FINDINGS
- II	disease or condition reaulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST a. DUE TO (6) B. HY/ C. DUE TO (6) C. DUE TO (6) C. DUE TO (6) A LO	OR AS A CONSEQUENCE OF): POGLYCEMIC OR AS A CONSEQUENCE OF): HBLE HEPATC OR AS A CONSEQUENCE OF): COHOL ABUSE	CEWULAR C	Part I. 24e, WAS AN PERFOR	AUTOPSY 2:	12 hrs. 12 hrs. 2 months Several yis 4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
- II	disease or condition resulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to co	OR AS A CONSEQUENCE OF): POGLYCEMIC OR AS A CONSEQUENCE OF): HBLE HEPATC OR AS A CONSEQUENCE OF): COHOL ABUSE	CEWULAR C	Part I. 24s. WAS AN	AUTOPSY 2:	12 hrs. 12 hrs. 2 months Several yis 4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?
- II	disease or condition reaulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to cause.	POBLYCEMIC OR AS A CONSEQUENCE OF): WBLE HEPATC OR AS A CONSEQUENCE OF): CONDITION OF AS A CONSEQUENCE OF): CONDITION OF AS A CONSEQUENCE OF): CONDITION OF AS A CONSEQUENCE OF):	CELLULAR C	Part I. 248. WAS AN PERFOR	AUTOPSY 2:	12 hrs. 12 hrs. 2 months Several yis 4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
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- II	disease or condition resulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to cause. Enter UNDERLYING CAUSE CONTRIBUTE TO CAUSE. DID TOBACCO USE CONTRIBUTE TO CAUSE. WAS CASE REFERRED TO MEDICAL EXAMINER?	OR AS A CONSEQUENCE OF): POGLYCEMIC POR AS A CONSEQUENCE OF): POR AS A CONSEQUENCE OF): CONOL ABUSE ISE OF DEATH YES 28. PLACE OF DEATH	the underlying cause given in UNCERTAL Check only one)	Part I. 24a. WAS AN PERFOR	AUTOPSY 2:	12 hrs. 12 hrs. 2 months Several yis 4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?
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ITEMS: 23 PART I, 27, PER MEO FILM G-718 12/22/94 t.t

tem#1 8 19a	Der	F H Fil	m# G-718	12/09	/91 R M	
tem#1,8,19a	STATE	OF MARYLAND	/ DEPARTMENT	OF HEALTH	AND MENTAL	HYGIE

	1 - STATE REGISTRAR		CERTIF	ICATE O	DEATH		REG. NO	_				
1000	1. DECEDENT'S NAME (First, Middle, Last) TERRENCE	0 0				2. DATE OF			YEAR	3. TIME OF DEATH		
	TERRANCE 4. SOCIAL SECURITY NUMBER	C. A.	E (In yrs. last birthday)	BLA		ECEMB	ER 6		994	2:08	Рм	
3	216-94-9256	1 🔀 M 2 🗆 F	29 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Sept	23, 1	1965	8. BIRTH Counts Nev	Yprky O	reign RK	
OH	9a. FACILITY NAME (If not institution, give : UNION MEMORIA)				OR LOCATION OF D	DEATH	EATH					
DIRECTOR	RESIDENCE OF DECEDENT									10d, INSIDE CITY		
	Md		Bal							V LIMITS?		
FUNERAL	100. STREET AND NUMBER 1222 Ramblewood F	load		21239						J S A		
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	O If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White,							en, K	
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPAT	TION	16b, Kil	ND OF BUS	SINESS/IN	DUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 2yrs	life. Do NOT u	Bondsma								
S	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N			Sumeme)				
BE	Paul Blair					n Cohe						
2	196. INFORMANT'S NAME (Type/Print) JACQUETTA Jacqueline L. Blair 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Ramblewood Road Balto, Md 21239											
	20e. METHOD OF DISPOSITION 1 Description Description		Ob. PLACE AND DATE			12994		cation –	City or To	wn, State		
	21. SIGNATURE OF PUNERAL SERVICE LI		hom 1	22. NAME Mar	ch F/H We	ACILITY						
	23. PART i Enter the diseases, pr	complications that caus	ed the daeth. Do i					ratory an	reat.	Approxima	ate	
	immediate cause (Fine) disease or condition resulting in death)	List Drily One cause Dri	eech line.	ONBO-EMBOLISM Interval Betwo								
		DUE TO (OR AS A CONSCOUENCE OF):										
NOIT	Sequentially list conditions, if any, leading to immediate DEEP VENOUS THROMBOSIS DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease Dr Injury that initiated eventa	c. DUE TO (OR AS	A CONSEQUENCE O	F):								
CERI	resulting in death) LAST	d								-		
DICAL	PART II. Other significent condition	a contributing to death	but not resulting	in the underlyle	ng ceuse given in		PERFOR	MED?	24b.	WERE AUTOPSY FIR AVAILABLE PRIOR T COMPLETION OF C	то	
						_ ''	YES 2	□ NO		OF DEATH?		
PHYSICIAN: ME	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	S 🗆 NO [UNCERTAI	N 🗆						
ਠੂੰ∥	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 26. PLACE OF DEATH (Check only one) OTHER:											
¥ ¥	27. MANNER OF DEATH	1 to Inpetient 2 ER/Ou 28e. DATE OF INJURY		4 - Nursing Ho	ne 5 - Residence			7.15-1				
BY P	Natural 5 Pending	(Month, Day, Year)		URY W	ORK? YES 2 NO	28d. DEŞCRI	BE HOW IN	NJURY OC	CURED			
- 11	2 Accident Investigation 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								oute Number,			
COMPLETED		CIAN: To the best of my kno								and manner as st	ated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	0 00 1	-		29c. LICENSE NU	MBER	T	29d. DAT	E SIGNED	(Month, Day, Year)		
2	Lleurs		ind		0.C.N	1.E.	DE	CEME	BER	8, 1994	1	
	30. NAME AND ADDRESS OF PERSON WH	D COMPLETED CAUSE OF D										
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE	n Stre	eet. Ba	Ltimor	e,	Mary	lan	d 21201		
	DEC 9 1994	Julia Danier	n-Rondold									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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MARYLAND 21215-0020	be retained by the hospital or attending physician
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BALTIMORE	Page 1
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DIVISION OF VITAL RECORDS, P.O. BOX 68

	1 - STATE REGISTRAR				IFICAT					REG. NO			
	Dobort Nod Discharge Year											3. TIME OF OEATH	
3	4. SOCIAL SECURITY NUMBER	R 1 YEAR	December 7.19 AR IF UNDER 24 HRS. 7, DATE OF BIRTH						11:30 P				
	170-18-3166	5. SEX 1 🔀 M 2 🗌 F	77	in yrs. last birth	S. MONTHS	DAYS	HOURS	MIN.	10	10 19	17	Pen	nsylvania
œ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9c. COUNTY OF DEATH									ATH			
ÖL:	Baltimore Baltimore												
DIRECTOR	10a. STATE 10b. C	10c	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?		
	MD	E	Baltimore								1 X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 5509 Cedella		101. ZIP CODE 21206						U.S.A				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2 NO NTES							fee or No— 14. RACE — American Inc Black, White, atc. Specify: White				
	15. DECEDENT'S (Specify only highest	S EDUCATION grade completed)	T	16a. DECEDE	NT'S USUAL C	CCUPATI	ON of work	ina	16	b. KIND OF BU	SINESS/INO		
COMPLE	Elementary/Secondary (0-12) 12 Years	Ilfe. Do N	Give kind of work done during most of working e. Do NOT use refred.) thographer						ompan	у			
5	17. FATHER'S NAME (First, Middle, La						1.00			Middle, Malden			
BE DE	Lloyd Black						Ar	melia	Ma	rch			
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanora Blackburn 5509 Cedella Avenue Baltimore, MD 21206												
	206. METHOD OPDERPOSITION 1												
	21 SHOWATURE OF FURENAL SERVICE LICENSEE The Dipper Tuneral Homes AND ADDRESS OF FACILITY The Dipper Funeral Home 7110 Belair Road Balto, MD 21206										ral HomeI		
	// shock, or heart failure. List failt one cause on each line.									Approximate Interval Betwo Onset and De			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST B. CORUNTATA A TONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.												
MEDICAL CI	PENFORMED? 1 YES 2 HO									WERE AUTOPSY FINDING NO. 10 COMPLETION OF CAUS			
ž	DID TOBACCO USE CO	ONTRIBUTE TO CAL	USE O	F DEATH	YES 🗆	NO E	UNC	ERTAIN					☐ YES 2 ☐ NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER?		- 1	B. PLACE OF	The second contract of the second	the second second		_					
2	HOSPITAL: 1 OPEN 2 DOA 4 Nursing Name 5 Sesidence 6 Other (Specify)												
ву рн	27, MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Near) 28s. TIME OF Sec. INJURY AT WORKY WORKY M 1 YES 2 NO							UNED					
	2 Accident Investigation 3 Suicide 8 Could not be determined Dulkling, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, fectory, office City or flowr, State) 28f. LOCATION (Street and Mumber or Rura City or flowr, State)								or Runel Ro	ute Numbec			
COMPLETED		PHYSICIAN: To the best of r											
	294 NGNATURE AND TITLE OF CER	AMINER: On the besis of ex	mination	and/or Investig	pation, in my	pinion, d	-			e and place, and		1.15	
8	10						ALC DO	ENSE NUMB	C.		and DATE	SIGNED /	MOHEN, Diny, Year)
0	NA X						111	112	5 3	Y	- 12	/	194

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

John Shavers MD 518 S. Camp Mead Road Linthicum, Maryland
31. DATE FILED (Month, Day, Year)
DEC 0 9 1994 Juli Saudion Review

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DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

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	THE NETRAL DIRECTOR: After this certificate has been signed by the attending physician and completely mied in by the funeral director, page 5 should be detached to the state between the state	INFORMANTIFIEM 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	N	뫍	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - STATE REGISTRAR	STATE OF M	MARYLAND / I		MENT OF H			AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	+ ER	III HERD	Sr.			2. DA	TE OF DEATH	AY .	YEAR 3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday) IF	UNDER I YEAR	IF UNDER 24		TE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)		
1.5	214-38-1439 9a. FACILITY NAME (If not institution, give si	1 M 2 F	51	YRS.	L CITY, TOWN C		OF DEATH	1171	43	Md.		
DR	130. TY, TOWN OR LOCATION OF DEATH 150. Secounty of DEATH 150. Secounty of DEATH 150. Secounty of DEATH											
ECT	RESIDENCE OF DECEDENT											
DIRECTOR	Md. Balto.											
	10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?											
FUNERAL	1306 Riggs Ave. 21217 USI											
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARM	D	If yes, spe	cify Cyban, I	Mexican, Puer	GIN? (Specify Yes to Rican, etc.)	s or No—	14. RACE — American Indian, Black, White, etc.		
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APLE	Elementary/Secondary (0-12)	College (1-4 or 5	F) .	abo				Cons	stru	ction		
CON	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER	R'S NAME (Firs	t, Middle, Malden	Surname)					
BE	James 19a. INFORMANT'S NAME (Type/Print)	all, D	<u>γ,</u>			/-	Anit		ohn:			
2	Mary Morris 1980. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nary Morris 1000 Shellbanks Rd. Balto, Md. 2/225											
	20s_METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE, 20c, LOCATION — City or Town, State											
- 14	21. SIGNATURE OF FINERAL SERVICE LICENSEE 12 Cremetion 3 Removal from State Commetory or other place) Removal from State Commetory or other place) Removal from State Commetory or other place) Removal from State Removal from											
	21. SIGNATURE OF TWEENAL SERVICE LIC	a 4	W		Ja W	NC5	A. M	orto	n + 3	Sons		
	23 PART I Frier the diseases or	U. I	urlon	th Da not	1701	Layr	rens S	H. Ba	110.	Md. 21217		
	23. PART I piter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory street, interval Between immediate CAUSE (Final											
	disease or condition a. Chronic obstructive pulmonary disease											
	DUE TO (OR AS A CONSEQUENCE OF):											
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	OR AS A CONSECU	JENCE OF):	1 -	y	scor	1				
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury											
불	thet initiated avents resulting in deeth) LAST	O I O	OR AS A CONSECU			Ca	20/1-		1			
CE		d. WILL						myo	par	491		
CAL	PART ii. Other significant condition	()		/	he underlying	cause give	en in Part I.	24a. WAS AN PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDICA	O CALL OF DEATH											
2 2	1 YES 2 NO											
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. PL	ACE OF OEAT	TH (Check only	one)				
HYS	1 YES 2 NO 27. MANNER OF OEATH	1,2 Inpatient 2	Home 5 ☐ Residence 6 ☐ Other (Specify)									
BY P	Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)		28b. TIME O	WO	JURY AT 28d. O		8d. OEŞCRIBE HOW INJURY OCCURED				
ED B	3 Sutcide 6 Could not be	28a. PLACE O building,	12.5	281. L	or Rural Route Number,							
MP	(Check only CERTIFYING PHYSI									d. cause(a) and manner as stated.		
18	296. SIGNATURE AND TITLE OF GERTIFIES					29c. LICENS		prince, et		SIGNEO (Month, Day, Year)		
B	(Ms Reh	war	~			01	+32-)	> /	2/54		
41 May 1	TO MAKE AND APPRECE OF DEDOCAL VAL											

ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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The man was the man and the ma	9	within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	RTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	RAL	2		
3	UNE	vithin	M	
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.												
1	1. DECEOENT'S NAME (First, Middle, Last)	2. DATE	OF DEATH	AY Y		. TIME OF DEA	ТН						
	JAIME BURRELL-SAHL								4	2:00	AM		
			SEY SACE (In um lost highday) STANDER & VESS STANDER & TOURS OF STANDER							ACE (State or Fe	oreign		
	1 402 30 3403	13K M 2 🗆 F	66 YRS.			Jül	y 19,	1928	Country)	wa			
OC.	99. FACILITY NAME (If not institution, give stre Suburban Hospit				OR LOCATION OF O	EATH		9c. COUNTY					
DIRECTOR	RESIDENCE OF DECEDENT	_dl		Bethes	da			Montg	ome	ry	<u>.</u>		
3EC	10e. STATE 10b. COUNTY		10c, CIT	TY, TOWN OR LOCA	TION				10	Dd. INSIDE CITY	1		
	Maryland Monto	gomery		Potoma	C				1	LIMITS?	NO		
AL	10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZEI	OF WH/	AT COUNTRY?			
FUNERAL	11607 Karen Dri				20854			USA					
Ξ	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 ₩ YES	U.S. ARMED		CENDENT OF HISPA			or No- 14	RACE -	RACE — American Indian, Black, White, etc.			
ΒY	3 Widowed 4 Divorced	FORCES? 1 VES IF YES, GIVE WAR OR DA WWII	TES		NO Specif		, , , , , ,	7.7	Specify:				
	15. DECEDENT'S EDUCA	ATION	16e. DECEDENT'S	USUAL OCCUPATE	ON .	16b	. KIND OF BU	SINESS/INDUS		E			
E.	(Specify only highest grade co	College (1-4 or 5+)	life. Do NOT u										
절	5-	-	Disabl	ed Vete	ran		Armed	Forc	es				
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA								
BE	Elmer Sahl						ulver						
2	19e. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Numi	ber, City or Tow	n, State, Zip Co	de)				
	Helga Burrell-S			as #10									
	1X Buriel 2 Cremation 3 Remov	rel from State com	etery cremetony or o	OF DISPOSITION (Nother place)		OAT		CATION — City					
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE!	NSEE AL.	lington	Natio	nal Cem	L. ILZ	7/94	ArMin	gto	n, VA			
	She Man	Perhie -			Pearson		neral	Home	S				
	Audum	aum		Falls	Church	VA	220	46					
	23 PART i. Enter the diseases, or co ehock, or heart failure. Li	mplicatione that caused ist only one cause on er	the death, Do	not enter the me	ode of dying, aud	ch as cere	flac or reepi	retory arrea	t,	Approxim			
	IMMEDIATE CAUSE (Final disease or condition	14 50			= 4					Onset and			
	resulting in death) e.	CONGESTI DUE TO (OR AS A	VE HI	YHLT E	HILVR	_		401	745				
_		RECURRE	CONSEQUENCE O	IF): VIII AAN A	DOU !	En	Pall			11111	ia.		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A			111-1 2	-401	50-1			yar	CKS		
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury									}			
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):									
H	reaulting in deeth) LAST												
AL C	PART II. Other algnificant conditions	contributing to death br	ut not resulting	in the underlyin	g cause given in	Part i.	24a. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FI	INDINGS		
S	PNEUMONI						PERFOR	RMED?		MILABLE PRIOR			
						_	1 YES 2	X1 NO		F DEATH?	NO		
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YI	ES NO [UNCERTAI	\square							
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)									
Si	The state of the s	HOSPITAL:	ntient 3 🗆 DOA	OTHER: 4 Nursing Hor	e 5 🗆 Reeldence	6 🗆 Othe	(Specify)						
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIM		URY AT	26d. DES	CRIBE HOW I	NJURY OCCUR	ED				
BY													
	3 Suicide & Could not be 4 Homicide determined	28s, PLACE OF INJURY building, etc. (Speci	— At home, term,	street, factory, offic	•		ATION (Street of Town, State)	and Number or	Rural Rout	te Number,			
E	0.0500500									_			
P P		AN: To the best of my knowle											
COMPLETED		On the beale of exemination	end/or investigation	on, in my opinion, o	leath occured at the	time, date	and plecs, en	d due to the c	euse(s) er	nd manner ee s	tated,		
H	296. SIGNATURE AND TITLE OF CERTIFIER	444			29c. LICENSE NUI			29d. DATE S	GNED (M	onth, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	OMPLETE CHILD		0.11	D2330	18		- D	EC.	05,19	194		
	VICTOR M. PRIEGO	O, MD //	420 ROG	CKVIU	E PIKE	Re	CKVI	UE, N	10	2085	2		
	JULION PMULGO, MD 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) VICTOR M. PRIEGO, MD 31. DATE FILED (Month, Day, Year) DEC 0 9 1994 July Develop Randally												

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	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be	THE CHRISTON PROPERTY. Above this accessions has been alread in the accordance about according to the decision of
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rours after death. Page 6 may be retained by the hospital or attending physician.	ar death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	val.
JMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	i examiner must be notified at once.
CONTROLLED BY DISCOUNT AND CONTROL OF THE CONTROL O	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPART			MENTAL HYGIEN	_					
	1. DECEDENT'S NAME (First, Middle, Last) HAZEL BR	ANCH				2. DATE OF DEATH MONTH	AY 7 4	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 254-58-0203	BIRTHPLACE (State or Foreign Country) VA										
TOR	98. FACILITY NAME (If not institution, give street and number) 96. COUNTY OF DEATH Johns Hopkins Bayview Medical Baltimore RESIDENCE OF DECEDENT											
DIRECTOR	MD 10a. STATE 10b. COUNTY			TOWN OR LOCAT altimo				10d. INSIDE CITY LIMITS? XXX YES 2 \(\square\) NO				
FUNERAL	1347 W. North	Ave.		101	21217	7	10g. CITIZE	USA				
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yea, spe		NC ORIGIN? (Specify Yan, Puarto Rican, etc.)	s or No — 14.	. RACE — American Indian, Black, Whita, atc. SpecifyBlack				
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION 1 College (1-4 or 5+)	life. Do NOT use	rk done during mo retired.)	on st of working Duty Nu	16b. KIND OF BU	SINESS/INDUS	TRY				
OM	17. FATNER'S NAME (First, Middle, Last)		1 -	1 4 4 5 6	*	ME (First, Middle, Maiden	Sumama)					
w l	Chester Smith					Murphy						
0 B	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural	Ploute Number, City or Tox		ode)				
٦	James H. Branch	ı, Jr.	1347	W. Nor	th Ave.	Balto.,	MD 2	21217				
	20a. METNOD OF DISPOSITION 1202 Auriel 2 Cremetion 3 Remove		LACE AND DATE OF		me of			y or Town, Stata				
	4 Donation 5 Other (Specify)	<u> </u>	g Memo	rial P	ark ID ADDRESS OF FA	12/12	Woodl	awn, MD				
	e. Les Ci	Mortin	<u> </u>	Jame 1701	s A. Mo Lauren	rton & S	,	uneral Home				
	IMMEDIATE CAUSE (Final	iat Dnly Dna causa Dn sac	ha daath, Do no h Ilna.	t antar tha mo-	da of dying, auc	h an cardiac Dr reap	fratory errest	Interval Between Onset and Death				
	resulting in death) a.	SEPSIS DUE TO (OR AS A C	ONSEQUENCE OF):					7 days				
TION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated aventa resulting in death) LAST CAUSE (Disease or Injury that Initiated aventa resulting in death) LAST											
	PART II. Other significant conditions	contributing to death but	not resulting in	the undariving	Causa diven in	Part i. 24a. WAS AN	AITTORSY	24b. WERE AUTOPSY FINDINGS				
PHYSICIAN: MEDICAL	ACUTE RENAL FAI MELLITUS, HEART	LURE, ANEM	IA, HYP	OVCLEM		DEDECO	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
ž	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	□ NO 🗷	UNCERTAIL	v 🗆						
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	PLACE OF DEATN									
YSI	1 YES 2 NO	1 Inpatient 2 ER/Outpati		OTHER:	5 🗆 Residence	8 Other (Specify)						
ву Рн	27. MANNER OF DEATH 1 P Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	TY WO	JRY AT RK? 'ES 2 NO	28d. DEŞCRIBE NOW	NJURY OCCUR	ED				
PLED !	3 Suicide 8 Could not be datermined	28s. PLACE OF INJURY — building, etc. (Specify)	At homa, farm, atr	net, tactory, office		28t. LOCATION (Street City or Town, State)		Rural Route Number,				
COMPLE		AN: To the best of my knowled						ause(a) and manner as stated.				
BE	Martha C. M.	e MD			29c. LICENSE NUN			IGNED (Month, Day, Year)				
5	30. NAME AND ADDRESS OF PERSÓN WNO MARKHAM C. LUKE	, MO, JOHN	is hopkin	rim) VS BAYV	1EW, 49	40 Eastern						
	DECO 9 1994	32 REGISTRAN'S MONAT	URE LL									



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

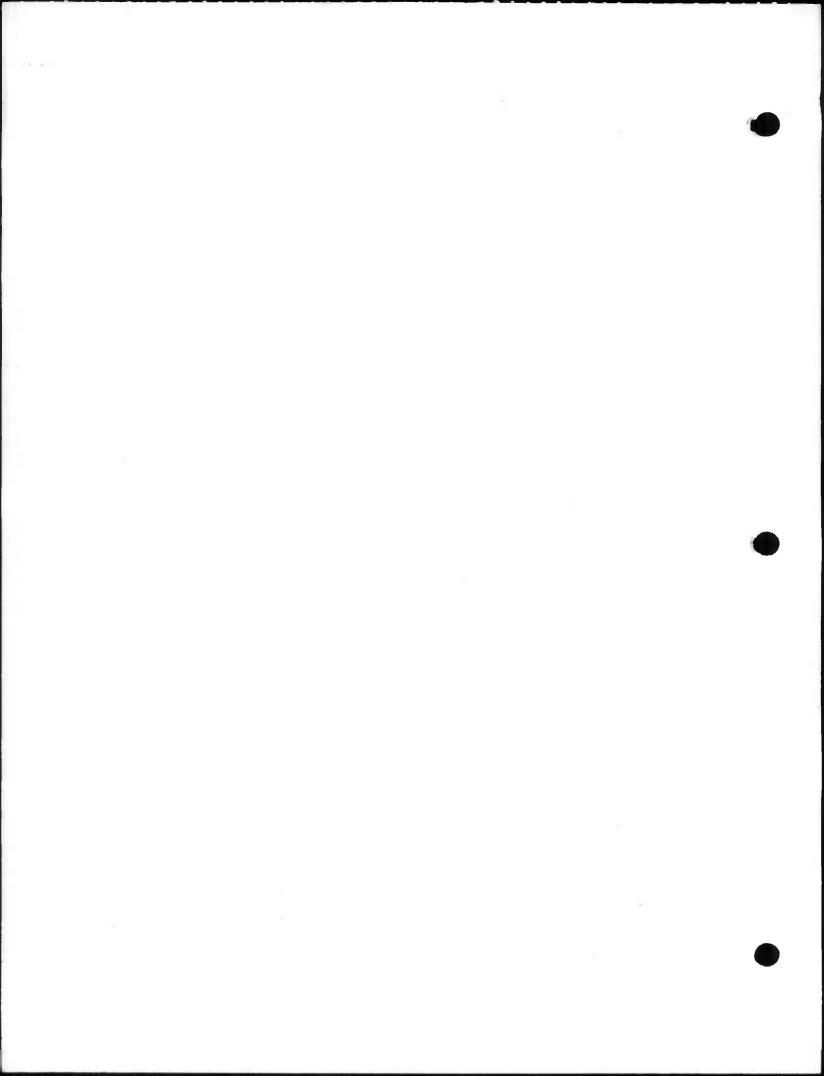
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL BYCIENE

	1 - STATE REGISTRAR CERTIFICATE OF DEATH	REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH	3. TIME OF DEATH								
- 3	MAGNOLIA COTTMAN	DECEMBER 04,									
1	4. SOCIAL SECURITY NUMBER 214-18-1462 5. SEX 6. AGE (In yrs. lest birthdey) 86 YRS. 6. AGE (In yrs. lest birthdey) 86 YRS. 6. AGE (In yrs. lest birthdey) 86 YRS. 86 YRS. 86 YRS.	APR. 2, 1908	8. BIRTHPLACE (State or Foreign Country) VIRGINIA								
TOR	96. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL 96. CITY, TOWN OR LOCATION OF DE. BALTIMORE CITY	ATH 9c. CO	n/a								
ᇤ	RESIDENCE OF DECEDENT		10d. INSIDE CITY								
L DIRECTOR	MARYLAND n/a BALTIMORE		V LIMITS? VES 2 NO								
FUNERAL	1400 E. MADISON STREET apt. 210 21205		TED STATES								
BĄ	11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuben, Mexicar 1 YES, GIVE WAR OR OATES A.A. 1 YES 2 NO Specify.	, Puerto Rican, atc.)	14. RACE — American Indian, Black, White, etc. SpecifyBLACK								
	15. DECEDENT'S EQUICATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSINESS/I	NOUSTRY								
COMPLETED	Elementery/Secondary (0-12) College (1-4 or 5 +) 3 RD - DOMESTIC	n/a									
8		AE (First, Middle, Malden Surneme	·								
BE (HENRY COTTMAN MAGNO										
٩	190. INFORMANT'S NAME (Typer/Print) ROBERT COTTMAN 190. MAILING ADDRESS (Street and Number or Rural R 1802 ELKRIDGE LANE,	RICHMOND, VI									
	20e. METHOD OF DISPOSITION 1 Seuriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory of other place). MT. ZION CEMETERY 12-		- City or Town, State VNE, MARYLAND								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACE WM. C. MARCH										
\neg	23. PART I. Entar the diaeases, or complications that causad tha death. Do not anter tha moda ot dying, such	as cardiac or respiratory a	arraat, Approximate								
	ahock, or haart fallura. Liet only ona causa on each lina.		Interval Between Onset and Death								
	disease or condition resulting in death) a. Due to (or as a conscouence of):	rost	5 minutes								
NO	Sequentially list conditions, b. CONON AND ARRY OSCUESC 10 XRQ 05										
CATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury		10 10019								
CERTIFICATION	that initiated evanta resulting in death) LAST										
	DART II. Other classificant and illumination of the control of the										
MEDICAL	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in i	PERFORMEO?	Y 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE								
ED	Diray Canta	1 TYES 2 NO	OF DEATH?								
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	1 30	1 TYES 2 NO								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	·/->									
SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence of	8 ☐ Other (Specify)									
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO	26d. DEŞCRIBE HOW INJURY O	CCURED								
	3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)	28I. LOCATION (Street end Numb City or Town, State)	per or Rural Route Number,								
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end piece, end due to the control of the best of my knowledge, death occurred at the time, date end piece, end due to the control of the best of my knowledge, death occurred at the time, date end piece, end due to the control of the best of my knowledge, death occurred at the time, date end piece, end due to the control of the best of my knowledge, death occurred at the time, date end piece, end due to the control of the cont										
	The state of the s										
TO BE	A Luces MD M63	BER 29d. D/	ATE SIGNEO (Month, Day, Year)								
	30. NAME AND ADDRESS OF PERSON W/O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	Balking	2 MN 7,200								
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	7177	7								
	DEC 0 9 1994 Juli Swaler Revell		DMM 46 D 470								





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

2

David

Stornelli

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

4940 Eastern Ave. Baltimore, MD

Approximate **Onset and Death** l day

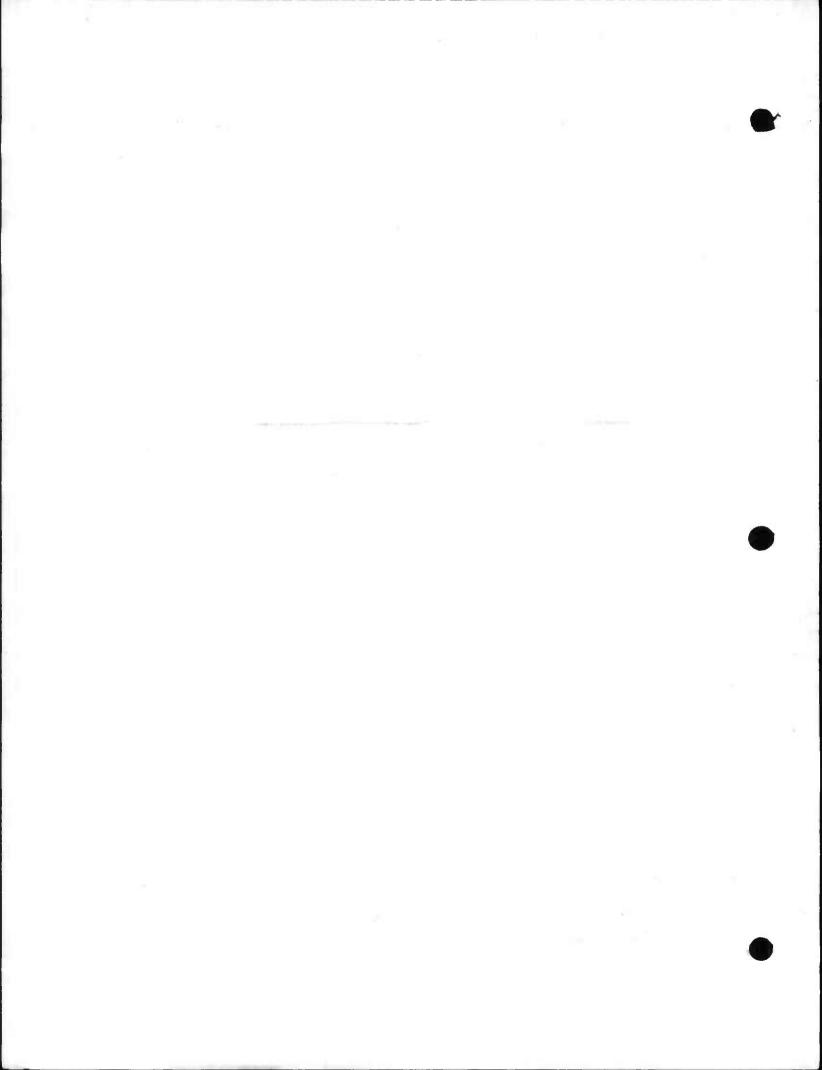
24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

21224

2 weeks

		1. DECEDENT'S NAME (First, Middle, Lest) Ellamay Capak								2. DATE OF DEAT	H 9 24v	YEAR	3. TIME OF DEATH 4:33 P
	21	4. SOCIAL SECURITY NUMBER 214-14-2758	5. SEX 1 M 2 X F	6. AGE (In yrs. I		IF UNDER	1 YEAR DAYS	IF UNDER 2 HOURS		7. DATE OF BIRTH (Month, Day, Vo. 5 - 12 - 1	07)	Count	NPLACE (State or Foreign lry) YLAND
, 2, 3 should	TOR	90. FACILITY NAME (If not institution, give: HOPKINS BAY V RESIDENCE OF DECEMENT		PITAL				I MORE	N OF DEAT			UNTY OF	
020 physician. bunal-transit permit. Pages 1,	DIRECTOR	MARYLAND 106. COUNT	Υ			LTIM							10d, INSIDE CITY LIMITS? 1 YES 2 NO
an. ransit pern	FUNERAL	212 S. HIGHLA					10	2122	24		10g. Cf	USA	WHAT COUNTRY?
21215-0020 If or attending physici for use as the burial-l	BY	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		NAR OR DATES	RMED NO	1	yes, sp			ORIGIN? (Specif Puerto Rican, etc			E — American Indian, ik, White, atc.
	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 8 YEARS	Cation completed) College (1-4 or 5	+)	Give kind of to. Do NOT us	work done d se retired.)	luring mo	ON ost of working	,	16b, KIND O	BUSINESS/IN	OUSTRY	
MARYLAND retained by the hospit 5 should be detached	i u		LENSKI					18, MOTNE		E (First, Middle, Me	iden Surname)		
	2	19a. INFORMANT'S NAME (Type/Print) MRS ANCES SAU 20a. METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Ren 4 Ponetion 5 Nother (Specify)	NDERS	20h BLACE	SAND DATE	1618 OF DISPOSI	BL TION (N			BALTI DATE 200	LOCATION -	- City or To	
SALTIN r death. Pag be funeral dir		1. NUMBER OF FUNERAL SERVICES		nudi	Y RU	22. 1 K A	CZC		SKI		L HOM	IE.	D. MD.
filled in the media		23. PART i. Enter the diseases, pr ahock, or heert feliure. iMMEDIATE CAUSE (Final disease or condition resulting in deeth)	Complication that List only one center of the center of th	uae Dn eech iin	leeth. Do i	not enter	the mo	de of dyin	g, such :	ss cardisc Dr r	espiretory a	rrest,	Approximate intervel Between Onset and Dea
68760, secured within and completely burial, crema		DUE TO (OR AS A CONSEQUENCE OF):											
SOX 68 tite be executed by sician and prior to burn trainmatic	SATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Pneumo	Onia (Or as a consi	EOUENCE O	F):							2 wee
P.O. The certification of the	CERTIFI	thet initieted events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):										
CO lires th Signed Health	JICAL	chronic obstr hip fracture	uctive	pulmor	nary	dis	eas	е		1 YE	S AN AUTOPSY REORMED? S 2 X NO	246	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	ÿ	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DE	ATH YE	SMN	10 [UNCE	RTAIN				
VITA IAN: The tifficate be State	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO	HOSPITAL:		CE OF DEAT	OTHER	:	e 5 🗆 Rasi	Idence 6	Other (Specify)			
ATTENDING PHYSIC STORY: Attention of a ster death with it is a ster death with	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WOR 1 Netural 5 Pending 28c. INJURY WOR 1 YEAR OF INJURY WOR 28c. INJURY WOR 1 YEAR OF INJURY WOR 28c. INJURY WOR 1 YEAR OF INJURY WOR 28c. INJURY WOR 1 YEAR OF INJURY WOR 28c. INJURY WOR 1 YEAR OF INJURY WOR 1 YEAR OF INJURY WOR 28c. INJURY WOR 1 YEAR OF INJURY WOR WOR 1 YEAR OF INJURY WOR WOR WOR WOR WOR WOR WOR W							M 1 YES 2000 She fell off of COU				
DIVISION DIRATTENDING P DIRECTOR: After thours after death	밑	4 Nomicide S Could not be detarmined	H	DME						At how	itate)		
	1 5 1	(Check only X CERTIFYING PNYS	R: On the best of a										s) and manner es atated.
TO THE HOSPI TO THE FUNER be filed within	O BE (2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion, death occurred at the time, data and pieca, and due to the ceuse(s) and my opinion at the time, data and pieca, and due to the ceuse(s) and my opinion at the ceuse(s) and my opini											

DHMH-18 Rev 1/89



DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF M	IARYLAND / DI Cer		ITMENT OF			MEN	TAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)								ATE OF DEATH	AY.	VFAR	3. TIME OF DEATH
	RICHARD M 4. SOCIAL SECURITY NUMBER	ilton			BERT			DE	EC. 07	199		2315 M
	216-28-2880	1 (X) M 2 F	6. AGE (In yrs. last bir	thday)	MONTHS DA	-	MIN.	(A	ATE OF BIRTH Month, Day, Year) V . 25	1929	6. BIRTHP Country)	Penna.
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TO	VN OR LOCAT	TION OF DE		14. 23		ITY OF DE	
OR	8203 BERRYFIE	LD DRIVE	1		WHI	EMAR	SH	er	ry Hall	BAI	TIM	ORE
DIRECTOR	10a. STATE 10b. COUNT			Dc. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY
	Maryland	Balt	imore				Peri	^y	Hall			LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER	03Berryfi	eld Drive			101. ZIP COI		123	6			States
ON	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. ARMED				OF HISPAN	VIC OF	RIGIN? (Specify Yea			- American Indian, White, etc.
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W				YES 2 X NO			irto Rican, etc.)		Specify	
	15. DECEDENT'S EDU (Specify only highest grade	CATION	18a. DECED		USUAL OCCUP				16b. KIND OF BUS	SINESS/IND	USTRY	MITT CC
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+	life. Do	NOT us	work done during se retired.) Claims		_			Insur	2000	
OMP	12 17. FATHER'S NAME (First, Middle, Last)	2	l'ias ce	1 (1α11115			ME (E)	irst, Middle, Malden		ance	
BE C		Lee Roy Co	lbert Sr.			10. 110			Mae Mc			
TO B	190. INFORMANT'S NAME (Type/Print) Dora G. Colbert								Number, City or Town			24.226
	20a. METHOD OF DISPOSITION		20b. PLACE AND	_	Berry		ווע	_	Baltir	CATION —		21236
	1 Durief 2 X Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from State	Hilltop	Se Se	ervice	Corp.	12,	1	. 1	Towso		Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE Milton	J Knight J		22, NAM	E AND ADDR	ESS OF FA	CILITY	Leonar	rdJ.	Ruck	, Inc.
	Milton	Knigh	1			Harf						. 21214
	23. PART I. Enter the diseeses or ahock, or heart fellure.	Liet only one cause	catteed the deeth se on each lina.	. Do r	ot enter the	mode of dy	ying, auc	h aa i	cerdiec or reepi	ratory arr	est,	Approximata intervel Between
	iMMEDIATE CAUSE (Finel disease or condition regulation in death)	. Conto	ict Gu	ns	hat	Was	ind	6	f Hea	id		Onset and Death
	disease or condition resulting in death) a. Contact Gunshof Wound of Head DUE TO (OR AS A CONSEQUENCE OF):											
0 0	Sequentially list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):											
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury	C										
CERTIFICATION	thet initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUE	NCE O	F):							
	DATE II Other classifiers a secondar	d										
CAL	PART II. Other algnificant condition	ne contributing to	death but not resu	iting	in the underl	ying cause	given in	Pert	1. 24e. WAS AN PERFOR			WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
ED I								_	1 DAYES 2	□ NO		DE DEATH?
z	DID TOBACCO USE CONT	RIBUTE TO CAI					CERTAI	V Z	1			
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 → YES 2 □ NO	HOSPITAL:	26. PLACE 0 ER/Outpatient 3 🗆 (OTHER:				2072 - 800000			
PHYSICIAN: MEDI	27. MANNER OF DEATH	28a. DATE OF (Month, Da	INJURY 26	b. TIM	4 □ Nursing I E OF 28c. URY	INJURY AT WORK?	taaldenca	_	DESCRIBE HOW IF	NJURY OCC	URED	/
BY	1 Natural 5 Pending 2 Accident Investigation	12/7/	94 2	300	9 M 1	YES 2	NO	50	elt infli	cted	d	sht
	3 Suicida a Could not be determined	28s. PLACE/OF building, s	injury — At home, etc. (Specify)	ferm, s	street, factory, o	office		281.	LOCATION (Street a City or Town, State)	203	Berry	Field Dr
	29e. CERTIFIER (Check only	ICIAN: To the best of a			d at the time.	data and plac	e, and due	to the		Co,	40 /	
COMPLETED		ER: On the basis of ax										and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R D.	000		5 H)		ENSE NUN					Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	IO COMPLETED CAUS				0.	.C.M	. E	•	PDE	.08	,1994
						eet,	Bal	ti	more, l	Mary	land	21201
	31. DATE FILED (Month, Day, Year) BEC 091994	32. BEGISTRAF	GIGNATURE PO	dell								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and least. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIEN	E		
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	WILMER H.	CRAMBLITI				DEC. 0	7, 1994	7:55 P. M	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	a. BIRT	THPLACE (State or Foreign	
- 1	215-10-0058	1 X M 2 □ F 84	YRS.	MONTHS DAYS	HOURS MIN.	FEB. 15, 191	O BAI	TO.,MD	
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN (OR LOCATION OF D				
DIRECTOR	NORTH ARUNDEL HO	SPITAL		GLEN	BURNIE		ANNE A	RUNDEL	
딦	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ	Y, TOWN OR LOCAT	ION		10d. INSIDE CITY			
HIC	MARYLAND	ANNE ARUNDEI			GLEN BUR	NITE		LIMITS?	
	10e. STREET AND NUMBER	THIND THOUDED			ZIP CODE	UNIL	10a, CITIZEN OF	1 YES 2 NO	
FUNERAL	500 SARATOGA AVEN	UE			21061		ľ	S.A.	
N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED		ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No.— 14. RA	CE — American Indian.	
	1 Never Married 2 Married	FORCES? 1 TYES			ecify Cuban, Maxico 2 NO Specia	an, Puerto Rican, atc.)	1	ck, White, atc.	
Э ВҮ	3 🕅 Widowed 4 🗌 Divorced				21			WHITE	
TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of w	USUAL OCCUPATION CORRESPONDED TO CORRESPOND	ON at of working	16b. KIND OF BUS	SINESS/INDUSTRY		
필	Elementary/Secondary (0-12) 3RD GRADE	College (1-4 or 5+)					EI EOMD I		
COMPLET	17. FATHER'S NAME (First, Middle, Lest)		TRUCK I	DRIVER		AME (First, Middle, Maiden	ELECTRI	LC	
	THOMAS CRAMBLITT					BEATBOCK	Surname)		
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street a		Route Number, City or Town	State Zin Code)		
2	MRS. BEATRICE DOR	IS BETCH				- BALTIMOR		21225	
	20a. METHOD OF DISPOSITION		PLACE AND DATE O	F DISPOSITION (Na	me of		CATION — City or		
	1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	LC Com	OUDON PAI	RK CEMET	ERY	12/9 BAL	TIMORE		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			D ADDRESS OF FA		•0		
	· // / / /	m Wc -				AL HOME, IN AVENUE-BALT		01000	
	23. PART i. Enter the diseeses, or o	complications that caused	the deeth. Do n	ot enter the mo	de of dying, suc	ch as cerdlec or respi	ratory arrest.	MD 21229 Approximate	
	shock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one ceuse on es	sch line.	1	11	//	, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death	
	disease or condition resulting in death)	Haile	Myon	udu	And	arch_		1 hers	
	resenting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	119			11	
Z	Sequentielly list conditions,	L Min	mee					de	
CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING								
임	CAUSE (Diseese or injury thet initisted events	C. DUE TO (OR AS A	CONSEQUENCE OF	3.					
E	resulting in deeth) LAST			,:				į	
		0.							
ÄL	PART il. Other significent condition	s contributing to death bu	ut not resulting i	n the underlying	g ceuse given in	Pert I. 24a. WAS AN PERFOR		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
PHYSICIAN: MEDIC						1 🗆 YES 2	NO	COMPLETION OF CAUSE OF DEATH?	
ME								1 YES TO NO	
AN	DID TOBACCO USE CONTI				UNCERTAI	N 🗆 📗			
S	EXAMINER?	HOSPITAL:	CACE OF OEAT	OTHER:					
HYS	27. MANNEY OF GEATH	1 Inpatiant ER/Output 28a. DATE OF INJURY	28b. TIMI			6 Other (Specify) 28d. OESCRIBE HOW IN	LILIEN OCCUBEO		
	1 Netural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK?	200. OESCHIBE HOW IP	JOH! OCCOREO		
ЭВУ	2 Accident investigation 3 Suicide E Could not	PLACE OF INJURY	— At home, ferm, s		- ///	28f. LOCATION (Street a	nd Number or Rural	Route Number,	
TED	4 Homicide determined	building, etc. (Speci	ny)			City or Town, State)			
COMPLET	29a. CERTIFIER 1- CERTIFYING PHYSI	CIAN: To the best of my knowle	edge, death occurre	d at the time, data	and place, and due	to the ceuse(a) and man	ner as stated.		
MO		R: On the basis of examination						(s) end manner as stated.	
ВС	29L SIGNATURE AND TOUR OF CENTING				29c. LICENSE NUI	MBER	29d. DATE SIGNE	D (Montly, Day, Year)	
ω	911/11	ma	5		0200		D 12/0	Stall	
임	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF CE	(ITEM 27) (Type.	Print)		` `	1	17	
	DR. ELLIOTT GORE	ATY - SUITE	<u> 203</u> – 78	45 OAKWO	OD ROAD	- GLEN BUR	NIE. MD	,	
	31. DATE FILED (Month, Day, Year) DEC 0 9 1994	32, REGISTRAR'S SIGN	TURE LE				,		
	DEC 9 1994	Jane a war							



BALTIMORE, MARYLAND 21215-0020

9 1994

Mudlerka

FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF OEATH CHARLETHA COOPER 3:30 A 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Mar DAYS HOURS YRS permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR 10a, STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY YES 2 NO FUNERAL WHAT COUNTRY? 100. STREET AND NUMBER 10f. ZIP COOE 10a. CITIZEN OF use as the bunal-transit hours after death. Page 6 may be retained by the hospital or attending physician. WAS OECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE — American Indian If yes, specify C 1 Never Married 2 Married NO BY Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/I 18a. DECEDENT'S USUAL OCCUPATION (Specify only high to. College (1-4 or 5+) funeral director, page 5 should be detached notified at once. BE 2 8 206. PLACE AND DATE OF DISPOSITION (No must injury, or other traumatic event, the medical examiner completely filled in by the cremation, or removal. me diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shops, or heart failure. List only one cause on each line. Interval Between IMMEDIATE PAUSE (Final **Onset and Death** disease of condition SEPTIC SHOCK OUE TO (OR AS A CONSEQUENCE OF): DAYS reaulting in death) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 prior to burial, PNEUMONIA WEEK CERTIFICATION and Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) attending physician cause. Enter UNDERLYING CAUSE (Disease or injury / the attending physid Mental Hygiene p QUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL een signed by the shows any 1 YES 2 | NO OF OFATH? 1 YES 2 NO DIRECTOR: After this certificate has been hours after death with the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF CEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending Investigation ВУ 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) TO THE FUNERAL DIRECTOR: At the filed within 72 hours after de IMPORTANT; It item 28 is 3 Suicide COMPLETED 6 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(s) end manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE merry 045770 1Z-8-2 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601 LOCH RAVEN DENNIS ROYIMPERIO GOOD SAMARITAN HOSP17A1 BALTIMORE, MD 2128, 31. DATE FILED (Month, Day, Year) 32. REGISTRA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

OHMH-16 Rev 1/89

12/4

FOR

ITEMS: 23 PART I, 27, PER MEO FILM G-718 12/16/94 t.t

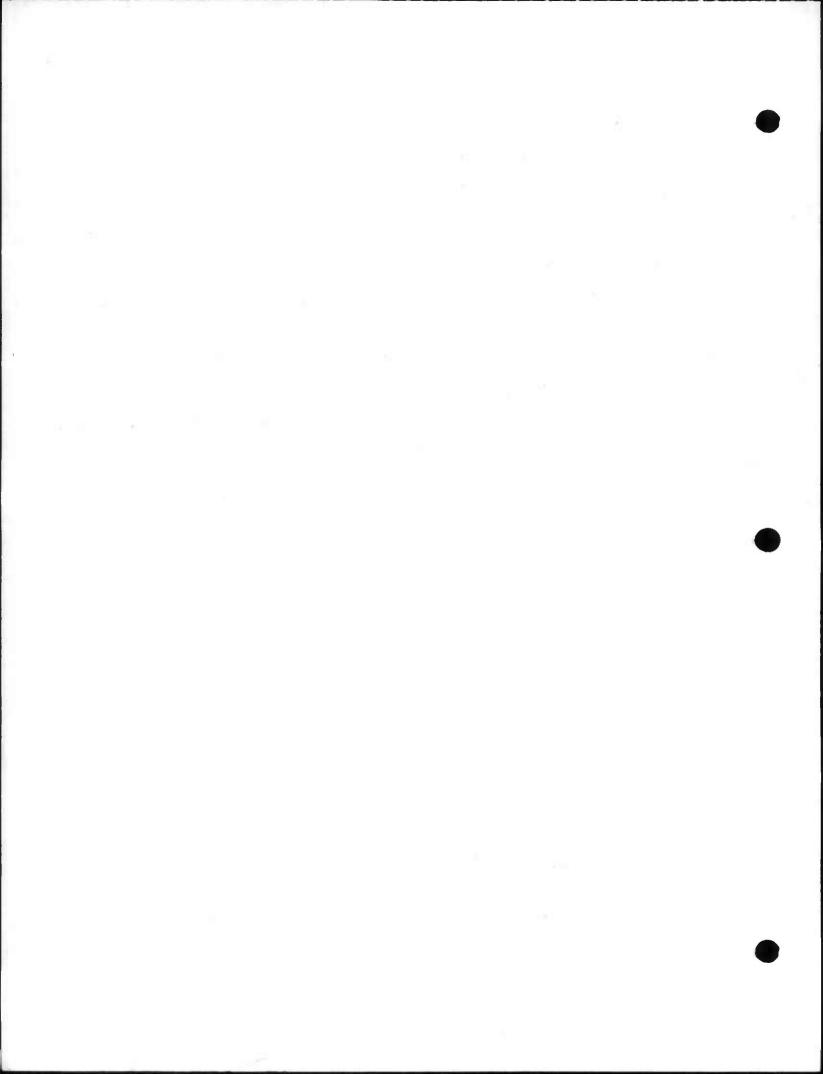
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			OTAT		. D.V.						
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	1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND / DEPAI CERTIF	RTMENT OF		MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) RICHMOND DAVIS	S SR.				MONT			EAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 242-52-4234		AGE (In yrs. last birthday)	IF UNDER 1 YEAR		(Mont	OF BIRTH h, Day, Year)		BIRTHP Country)	LACE (State or Foreign
~	9e. FACILITY NAME (If not institution, give str	eet end number)			OR LOCATION OF D					
ē l	UNION MEMORIAL HOSPITAL BALTIMORE CITY RESIDENCE OF DECEMBER RESIDE									
DIRECTOR	10e. STATE 10b. COUNTY		10c, CI1	TY, TOWN OR LOC			IOd. INSIDE CITY LIMITS? YES 2 NO			
	10e. STREET AND NUMBER	4			of. ZIP CODE	10g. CITIZEN OF WHA				AT COUNTRY?
FUNERAL	4121 The A)				212	_			15	
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Nidowed 4 Divorced	Married 2 Merried FORCES? 1 YES 2 HO If yes				an, Puerto	4? (Specify Yea Ricen, etc.)	or No —	Black,	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		life. Do NOT u	work done during i se retired.)	nost of working			SINESS/INDUS	TRY	
MP			Reti	Red - :	Self Gmp					·
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, M Denn's DAVIS 18. MOTHER'S NAME (First, Middle, M ARI) CI						Middle, Meiden	Sumema)		
H	190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stree	end Number or Rural	Route Num	ber. City or Tow	n. State. Zip Co	ode)	
ᄋ										2/2/8
	MARY DAVIS 200. METHOD OF DISPOSITION 1 A Surisi 2 Cremetion 3 Removal from State 4 Donetton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Betts Funeral Home 12. NAME AND ADDRESS OF FACILITY Betts Funeral Home 13. Part of the property of the part of									N. C.
i	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22, NAME	AND ADDRESS OF F	CILITY	19/	16		70.07
	(Vatricia B	IL		B	29 N.C	AROL	ine	1000	クル	13
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): B. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. C. C. DORSON OR CONSEQUENCE OF):									
	that initiated evente resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY FINDINGS									
PHYSICIAN: MEDICAL						_	24a. WAS AN PERFOR	RMED?	0	VERE AUTOPSY FINDINGS WALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\square\) NO
Y Y	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUIE IO CAUSI	26. PLACE OF DEA			ΝЦ				
2	EXAMINER? XXXYES 2 NO	HOSPITAL:	Outpetlent 3 DOA	OTHER:	me 5 Residence	6 🗆 Othe	er (Specify)			
Ē	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJU (Month, Day, Ye	JRY 26b, TIN	JURY Y	JURY AT YORK?	28d. DES	SCRIBE HOW I	NJURY OCCU	RED	
D BY	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home building, etc. (Specify)				YES 2 NO		ATION (Street or Town, State)		or Rural Route Number,	
	4 Homicide determined									
COMPLEIED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINER	IAN: To the best of my less of the bests of examination in the bests of examination in the best of examination in the best of								and menner es stated.
шШ	29b. SIGNATURE AND TITLE OF CERTIFIER	(V)				MBER		29d. DATE S	IGNED (Aonth, Day, Year)
2		Vu			0.C.	M.E		DEC		07/94
	DOWN A REPRESENTATION OF PERSON WHO	ver 1	lll Penn		t, Balt:	imor	e, Ma	rylan	nd 2	21201
	DECU 9 1994	32. REGISTRAR'S								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020



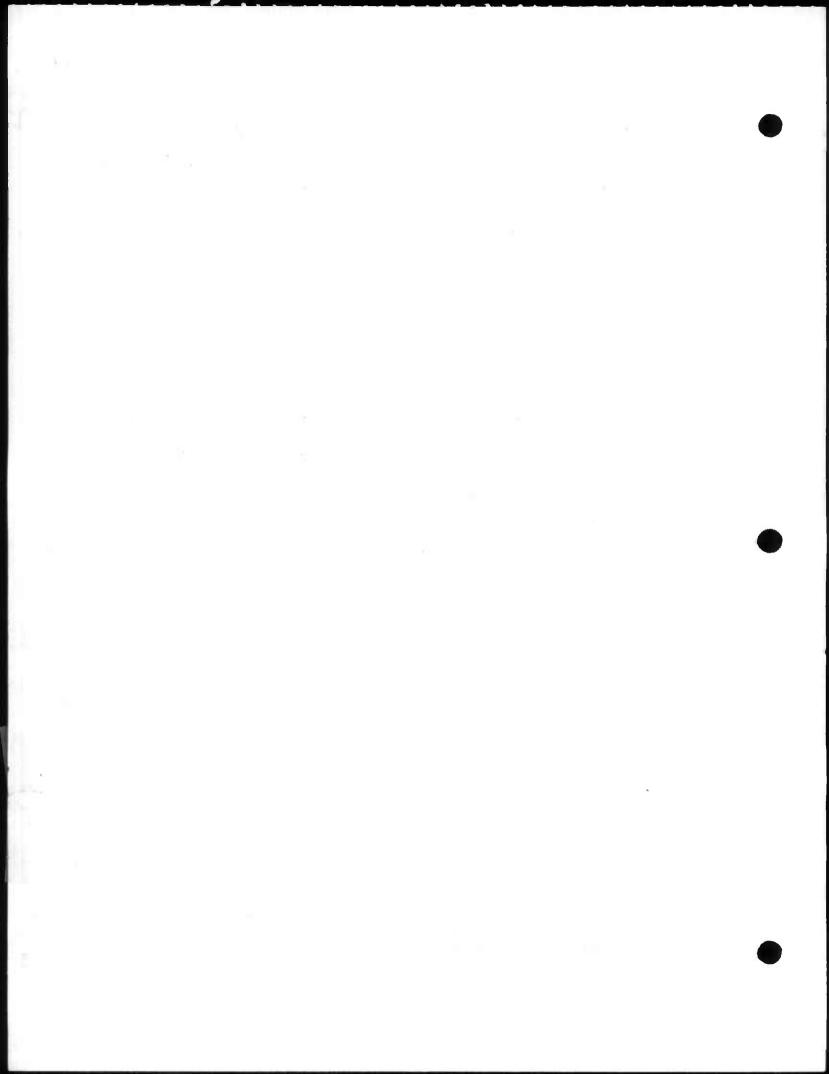
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BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed within properties after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State floor of Health and Alertal Huriane notor in huital comparison or seneral
OF VITAL RECORDS, P.O. BOX 68760,	e executed within	an and complete
.O. BO	n certificate by	nding physicis
RDS, F	at the death	by the atte
RECO	requires th	been signed
VIIAL	AN: The law	ifficate has bent
S	IG PHYSICIA	ter this cert
NISIO	3 ATTENDIN	RECTOR: After des
בֿ	DSPITAL OF	TO THE FUNERAL DIRECTOR
	TO THE H(TO THE FL.

			+ -					2 2	00021	
		FOR STATE REGISTRAR	STATE OF MARYL			HEALTH AND M F DEATH	ENTAL HYGIEN REG. NO.	E		
		Decedent's NAME (First, Middle, Lest) Herbert Milton Social Security Number					2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE OF DEATH DATE OF DAT	199		
		577-38-4576	1 🛣 M 2 🗆 F	(In yrs. lest birthday) 67 yrs.	IF UNDER 1 YEAR	I IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	27 M	i. BIRTHPLACE (State or Foreign Country) Innesota	
	ECTOR	99. FACILITY NAME (# not institution, give single 1931 Old Annagers) RESIDENCE OF DECEMENT	200	Y OF DEATH Arundel						
	DIREC	10e. STATE 10b. COUNTY	Arundel	10c cit An	y, TOWN OR LOO napoli	CATION			10d. INSIDE CITY LIMITS? 1	
	FUNERAL	1931 Old Annapolis Blve. 100, ZIP CODE 21401							EN OF WHAT COUNTRY?	
	B≺	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yea,	ECENDENT OF HISPANIC specify Cuben, Maxican, ES 2 No Specify:	ORIGIN? (Specify Yes Puarto Rican, etc.)		4. RACE — American Indian, Black, White, atc. Specify: White	
	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	Iffe. Do NOT us	work done during se retired.)	Agent	Giant			
s at once.	BE COM	17. FATHER'S NAME (First, Middle, Last) Leroy Daniels					E (First, Middle, Maiden Anderse			
be notified	TO B	19a. INFORMANT'S NAME (Type/Print) Marjorie E. Daniels 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Old Annapolis Blvd. Annaplis, MD 21401								
		20a. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State	netery cremetory of a Remont	cher clace) me t	cery 1	2/9 Day	vidso	onville, MD	
or removal. medical examiner must		21. SIGNATURE OF ELINERAL SERVICE LIC	Andf.	//		and address of facil desty Fun Ridgely A			O.A. .s, MD 21401	
event, the		23. PART I. Enter the diseases or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or haert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS) CONSEQUENCE OF): Approximate interval Between Onset end Death 2 years								
or other traumatic e	ATION	Sequentially liet conditions, if any, leading to immadiate cause. Enter UNDERLYING								
	CERTIFICATION	CAUSE (Disease or Injury that initieted events resulting in deeth) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	F):					
shows any injury,	MEDICAL C	PART II. Other eignificent conditions	contributing to death b	out not reculting i	in the underly	ing ceuse given in Pe	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
23 sho		DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	OF DEATH YE		UNCERTAIN			1 TES 2 NO	
or item	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Out		OTHER:	ome 5 Realdence 6	Other (Specify)			
marked,	ВУ РН	27. MANNER OF DEATH Netural 5 Pending Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY	NJURY AT 2 NORK? YES 2 NO	8d. DEŞCRIBE HOW II	IJURY OCCU	RED	
28 is	ETED	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	r — At home, ferm, s	streef, factory, of	fice 2	81. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,	
= =	COMPL		CIAN: To the best of my known: On the basis of examination						ceuse(a) and manner as stated.	
IMPORTANT: If	O BE C	296. SIGNATURE AND TITLE OF CERTIFIER PR SCAMM	Oleila			D465		29d. DATE S	SIGNED (Mahrin, Day, Year)	
	Ĭ	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	JONNS	Print) Volv	us Discore		2 60	Baltimoe MG	

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)
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BALTIMORE, MARYLAND 21215-0020

ermit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit por filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
THE CL	TO THI be filed	IMPO	

	1 - STATE REGISTRAR	STATE OF M			TMENT				MENTA	L HYGIEN	E		
3	1. DECEDENT'S NAME (First, Middle, Last) Mary Frances Da	avis							MONT	of DEATH mber 0	¥, 1°	994	3. TIME OF DEATH
1		5. SEX 1 M 2 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE	of BIRTH h, Day, Year) e 10,	1905	Countr	PLACE (State or Foreign n) aryland
TOR	90. FACILITY NAME (# not institution, give str Villa St. Michael			9b. CITY,		time		ATH		9c. COU	NTY OF D	EATH	
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE C LIMITS? XIX YES 2			
FUNERAL	3600 West Franklin Street 3N					101	ZIP CODE	21229	9		10g. CITI		WHAT COUNTRY? USA
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				RMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y If yes, specify Cuban, Maxican, Puerio Rican, etc.) 1 YES 2 NO Specify:					f? (Specify Yes Rican, etc.)			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+	(Gi	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working to NOT use refired.) COOK 16b. KIND OF					. KIND OF BUS	Domes			
BE CON	17. FATHER'S NAME (First, Middle, Last) William B. Johnso	on						ers nai		Middle, Malden Sh	Surname)		
10	19a. INFORMANT'S NAME (Type/Print) Edith O. Hinton								t. A		M Bal	Lto,	Md. 21229
	4 Donation 5 Other (Specify)			patory or o		ery]		3/94	E 20c. LO Lan	cation — sdowi	city or To	wn, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	B.C	pl				d addres		(Service 1. 21215
	23 PART I Enter the diseases, or part ahock, or heart failure. LIMMEDIATE CAUSE (Final disease or condition resulting in desth)	lat only one caus	ea on each line	•	not anter	tha mo	da of dyle	ng, such	n as can	diac or reapl	ratory arr	rest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									20 years			
	PART II. Other significant conditions Devent	contributing to	dasth but not r	esulting	n tha un	darlying	causa g	iven in I	Part i.	24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	IBUTE TO CAU	JSE OF DEA	TH YE	S \square N	10 P	UNC	ERTAIN		1 YES 2	NO.		DF DEATH? 1 YES 2 NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	H (Check o	inly one)							
Y PHYS	27. MANNED OF DEATH 1 Matural 5 Pending	28a. DATE OF I	NJURY	28b. TIM	-	28c. INJU WOI	RK?		_	r (Specify) SCRIBE HOW II	NJURY OCC	CURED	
TED BY	2 Accident 3 Suicide 8 Could not be detarmined	25a. PLACE OF building, 4	INJURY — Al hor rtc. (Specify)	me, farm, s	street, facto				28f. LOC City	ATION (Street a or Town, State)	and Number	or Rural F	noute Number,
Suicide 8 Could not be detarmined building, etc. (Specify) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause of the country of the best of the best of examination and/or investigation, in my opinion, death occurred at the lime, date as) and manner as stated.		
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D 12 B 200 12 B 200 13 NATI AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IZEM 27) (Size Office)								1					
	JOHL MESHUAN DATE FILED (Month, Day, Year)	32. REGISTRAR	S HAN		Print)	71	BAC	Ti Mo	VE	Mo	2123	0	
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	FOR 1 STATE	STATE OF MA	ARYLAND /	DEPAR	RTMENT OF	HEALTH AND	MENTA	L HYGIEN	E			
	REGISTRAR				ICATE O			REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	Amma Maa-	D	1_			MONT			YEAR	3. TIME OF DEATH	
	3. SOCIAL SECURITY NUMBER		ni Dic		IF UNDER 1 YEAR	IF UNDER 24 HRS.	_	ember of Birth	/, I		7:36 a.	
	217-48-4750	1 □ M 2 🕁 F	89 yea		MONTHS DAYS		(Monti	h, Day, Year)	1005	Country)	vland	
	9a. FACILITY NAME (If not institution, give s			15		OR LOCATION OF D		1/,		NTY OF DEA		
OR	Northwest Hospi	tal Center	-		Randa	allstown			Ва	altimo	ore	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b, COUNTY	1		10c. CIT	Y. TOWN OR LOC	ATION				13	IOd. INSIDE CITY	
E	Maryland	Baltimore	2			Randa1	lstor	ντη			LIMITS?	
FUNERAL	10e. STREET AND NUMBER	_		1	1	IOF. ZIP CODE			10g. CIT		IAT COUNTRY?	
	5412 Old Court Roa						133			ited S	States	
2	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT (FORCES? 1	YES 2	RMED NO	If yes,	ECENDENT OF HISPA specify-Cuban, Maxic	NIC ORIGIN en, Puerto I	f? (Specify Yes Rican, atc.)	or No-	14. RACE - Black,	- American Indian, White, etc.	
	3 Wildowed 4 Divorced	IF YES, GIVE WAR	R OR DATES		1 🗆 YE	E S \$₹\$NO Speci	fty:			Specify:	Caucasian	
3	15. DECEDENT'S EDUI (Specify only highest grade		18e. DE	CEDENT'S	USUAL OCCUPAT	TION most of working	16b	. KIND OF BUS	SINESS/IN	DUSTRY		
LET	Elemantary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT u	se retired.) Never v							
COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	AME /First	Mirkle Meiden	Sumamal			
ш	Jos	shua Dick	ζ.						Mc Car	n		
0 8	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Ru Dee Tungers 5 Hingate Conth Time							Tural Floute Number, City or Town, State, Zip Code)				
٦	Dee Jungers 5 Wingate Garth Timonium, MD 21093 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town, Sta											
	1 Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, cre	AND DATE	OF DISPOSITION (_{Name of} Ch.Cemete	DAT	20c. LO				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE)	Linory	meti		AND ADDRESS OF F		Λ ΤΦ	Sti	reett,	, Maryland	
	+ Choop of C	2. Kells	101/			ng Byers						
\dashv	23. PART I. Enter the diseases, or o			esth. Do	8/28	LibertyR	d Rar	ndalls	town	MD 21	133-4784 Approximata	
	shock, or heart failure. List only one cause on each iins.										intsrval Bstwee	
	disease or condition \rightarrow s. Car dige arrest											
	DUE TO (OR AS A CONSEQUENCE OF):										11111	
5												
ξ	If any, isading to immediats cause. Enter UNDERLYING											
RTIFICATION	CAUSE (Disease or injury C. DUE TO (OR AS A CONSEQUENCE OF):											
	resulting in death) LAST	d										
′	PART ii. Other significant condition	s contributing to de	sath but not	resulting	In the underlyl	ng causs given in	Part I.	24a. WAS AN			VERE AUTOPSY FINDINGS	
EDICAL	ASEYD	- ly	neste	nn	in			PERFOR	3.4	0	WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
¥										- 1	☐ YES 2 ☐ NO	
ğ	DID TOBACCO USE CONTI	RIBUTE TO CAU					ИП					
SICIAN:	EXAMINER?	HOSPITAL:			TH (Check only one OTHER:	***						
	27. MANNER OF DEATH	28a. DATE OF IN	IJURY	28b. TIM	E OF 28c. If	yJURY AT		CRIBE HOW II	NJURY OC	CURED		
	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	rear)	IN.		VORK? YES 2 NO						
	3 Suicida 8 Could not be datermined	28s. PLACE OF I building, etc	INJURY — At ho c. (Specify)	me, tarm,	street, factory, off	ica		ATION (Street a or Town, State)	and Number	or Rural Rou	ite Number,	
1	200 CERTIFIED											
		CIAN: To the beat of my										
3	2 MEDICAL EXAMINE		mination end/or	investigatio	on, in my opinion,	death occurad at the	time, date	end placa, en	d due to th	ne ceuse(s) a	ind menner es stated.	
ᇜᅦ	296. SIGNATURE AND TITLE OF CERTIFIER	110 (14	- Alex	1 4 1	Tres	29c. LICENSE NU	MBER	,	29d. DAT	E SIGNED (A	Aonth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type	Print)	1 VI4	618			14- 8	5-42	
	BIENVENIBU R	MATOS				OOK Rd.	7011	LEVSI	1111	M	4.21030	
11	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S	S SIGNATURE	- 1- P	111111111111111111111111111111111111111	10 07	26,	/ - 1		-,	0	

31. DATE FILED (Month, Day, Voar)
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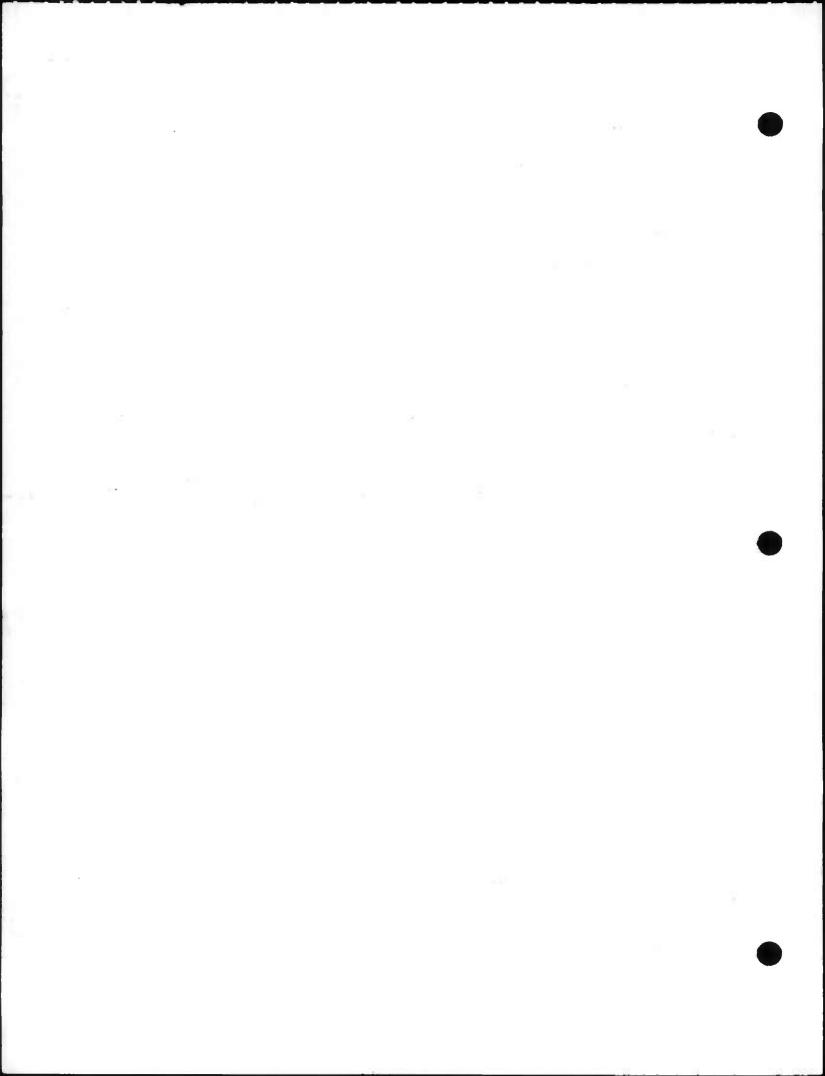
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death and seemed the filled provided by the attending physician and wental Hypene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is maked or how 2 shows any injury, or other traumatic event, the medical examiner must be notified at once. And or ham 22 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATH MONTH DAY	YEAR	3. TIME OF OEATH		
	Anna	Epps	3			1994	M		
- 1	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE		UNDER 1 YEAR IF UNDER 24 HRS.	7 DATE OF BIRTH	8. BIRTH	PLACE (State or Foreign		
	218-05-9692	1 🗌 M 2 💢F	80 YRS. M	NTHS DAYS HOURS MIN.	AUG. 15,	1914 N Country	Carolina		
	9a. FACILITY NAME (If not institution, give s	treet and number)	9	. CITY, TOWN OR LOCATION OF D		9c. COUNTY OF D			
E I	Seton Manor Nurs	ing Home		Baltimore		N/A			
ਰੋ	RESIDENCE OF DECEDENT								
DIRECTOR	10a. STATE 10b. COUNT			OWH OR LOCATION			10d. INSIDE CITY LIMITS?		
	MD N/	A	Balt	imore			1 X YES 2 NO		
₹ I	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF W	HAT COUNTRY?		
FUNERAL	1714 Linden Aven			21217		U.S.A.			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES		13. WAS DECENDENT OF HISPA If yea, specify Cuban, Maxic	NIC ORIGIN? (Specify Yes	or No — 14. RACE	— American Indian, , Whita, atc.		
BY	1 Never Married 2 Married 3 Wildowed 4 Olvorced	IF YES, GIVE WAR OR		1 TYES 2 NO Speci		Specif	v:		
	11	l	1				Black		
1	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during most of working	16b. KIND OF BUSI	NESS/INOUSTRY			
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)	BAKER	nired.)	STATE	of MARYL	ONA		
COMPLETED	8th 17. FATHER'S NAME (First, Middle, Last)	N/A	DANER				1110		
	Robert Bordeaux				AME (First, Middle, Maiden S	Surname)			
B	19a. INFORMANT'S NAME (Type/Print)				Bradley				
2	Minnie Washingto	n	1520 Mc	oness (Street and Number or Rural osher Street/Ba	Ploute Number, City or Town,	, State, Zip Code) 7 21217			
	20a. METHOD OF DISPOSITION								
	tXXBurial 2 Cremation 3 Ram	oval from State	DE PLACE AND DATE OF I	Place METEDV 1		ATION — City or To			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF EUNERAL SERVICE LIC		7	22. NAME AND ADDRESS OF F		DOWNE, M	IARTLAND		
	► Unanni	Ma	/	March Funeral	L Home East	TMODEL ME	21202		
_		U CALHER		1101 E. NORTH			21202		
	23. PART i. Enter the diseases, or c shock, or heart fellure.	complications that cause List only one cause on	ed tha daath, Do not aach lina.	entar tha mode of dying, suc	ch as cardiac or raapin	atory arreat,	Approximata interval Between		
	IMMEDIATE CAUSE (Final disesse or condition	A	. 1-,-	· D	CONC	imin o	Onset and Death		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Melas lœué Prumery Carcurur g Due to (or as a consequence of):								
		DUE TO (OR AS	A CONSEQUENCE OF):		40	er			
EDICAL CERTIFICATION	Sequentially list conditions,	b							
AT	if any, leading to immediate cause. Enter UNDERLYING	332 10 (011 710	A SOMOZOOZNOZ OV.	Qualeles 1	Melleles		i l		
윤	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF):	7000			<u> </u>		
E	resulting in death) LAST	4							
뜅									
A	PART II. Other aignificant condition	a contributing to death	but not reaulting in t	ha underlying cause given in	Part i. 24s. WAS AN A		WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO		
음					t 🗆 YES 2	□ NO	COMPLETION OF CAUSE OF OEATH?		
Σ							1 - YES 2 - NO		
z	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YES	□ NO □ UNCERTAI	N 🗆				
§	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEATH						
HYSICIAN	1 TES 2 NO	1 Inpatiant 2 ER/Ou		THER: Nursing Home 5 Rasidenca	6 Other (Specify)				
7	27. MANNER OF OEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCURED			
8	t Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO					
	3 Suicide 8 Could not be	28a. PLACE OF INJUF building, etc. (Sp	Y — At home, term, stre-	ol, factory, offica	261. LOCATION (Street an City or Town, State)	nd Number or Rural R	oute Number,		
	4 Homicide detarmined								
2 1	29e. CERTIFIER CERTIFYING PHYSI	CIAN: To the best of my kno	wledge, death occurred a	t the time, deta and place, and du-	e to the cause(a) and mann	her ea stated.			
COMPLETED				n my opinion, death occured at the			and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIES	1		29c. LICENSE NU	MBER	29d. DATE SIGNEO	(Month Day Year)		
				The second in the		THE STORES	up. wright, word, 10ml/		
B	5	(laurel		1 1):	206001	17.1	6194		
TO BE	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF O	EATH (ITEM 27) (Type, Pri	m) D3	3064	12/	6199		
	30. NAME AND ADDRESS OF PERSON WHE 821 W. EUtaw.	O COMPLETEO CAUSE OF O	EATH (ITEM 27) (Type, Pri	Ba Hia al Di	21201	12/	6199		
	02/4/ - 1-	O COMPLETEO CAUSE OF O 5 + 5+E	308 (Batio, M.D	, 2120(12/	6199		



BALLIMORE, MARYLAND 21215-0020	or death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not be sent to be successed by the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	examiner must be notified at once.
_	urs afte	ed in by t	medica
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THENDING PHYSICIAN: The law requires that the death certificate be executed within A was after death. Page 6 may be retained by the hospital or attending physician.	HALD DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Internation, or removal.	Ell item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O.

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - STATE REGISTRAR		SIAIL OF I	MARI LAND	CERTIF	ICATE C	F DEAT	H	WENTAL IT	G. NO.			
1. DECEDENT'S NAME (First	, Middle, Last)						-	2. DATE OF D	EATH			3. TIME OF DEATH
TLLTAN CATH	HERINE	ERDMAN						MONTH	DAY	3 1	994	12:55 24
4. SOCIAL SECURITY NUME		5. SEX	8. AGE (In yrs.	lest birthday)	IF UNDER 1 YE	AR IF UNDER	24 HRS.	7. OATE OF BI	RTH		8. BIRTI	IPLACE (State or Foreign
163-50-4656		1 🗆 M 2 📝 F	96	YRS.	MONTHS DAY	S HOURS	MIN.	(Month, Day,	1898		Countr	MORE, MD.
9s. FACILITY NAME (If not in	stitution, give s	treet and number)	- 00		9b. CITY, TOV	VN OR LOCATIO	N OF D		1000	9c. COL	JNTY OF D	
MANOR CARE-RUX	CTON									DALT	IMORE	
RESIDENCE OF DEC					1					DALI	THUBE	
10a. STATE	10b. COUNT	4		10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY LIMITS?
MARYLAND	BALTIMO	RE		TOWS	XON							1 TYES 2 TO NO
10e. STREET AND NUMBER						10f. ZIP CODE				10g. CI	TIZEN OF V	WHAT COUNTRY?
7001 N. CHARLES	ST.					21204				U	SA	
11. MARITAL STATUS		12. WAS DECEDER FORCES?	IT EVER IN U.S.					NIC ORIGIN? (Sp an, Puerto Rican,		or No—	14. RACI Blac	E — American Indisn, k, Whita, stc.
1 Never Married 2 X			MAR OR DATES	*			Specif		,,		Spec	
		<u> </u>						T			I WHO	LIE
(Specify onl	EDENT'S EDU y highest grade	completed)	16a.		work done during		9	16b. KINI	OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5						1 101 105	VCCD.	7.10		
17, FATHER'S NAME (First, M	ficially 1 and		IHU	USEWIFE		40 110-	EDIO M	HOUSE				
									, Malden	oumame)		
HERBERT O. SCH				401 000 000				HIPLEY		0		
19s. INFORMANT'S NAME (урел-тіпі)							Route Number, Co				
JOAN R. VOIT	1041		200.00				203	HUNTERSY				
1 Durial 2 Crematic	on 3 🗆 Ram	oval from Stata	_of ceme	tary, cremator	E OF DISPOSIT y or other place,			DATE			- City or To	
4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA		PENCEE	_ IPARKW	OOD CEV	ETERY DE	E AND ADDRES			BALTI	MORE	MAR)	(LAND
D POWER	L SERVICE LI	DENSEE						HOME, INC				
UB9SAhr	Hum	nal dan	o In	c.	7/01	PELATE D	SUVU JHE L	BALTIMOR	ME ME	21	226	
23. PART I. Enter the d												Approximate
IMMEDIATE CAUSE (Fi		Liet only one ce	Oaa on aach	iiria.	-	·	1					Interval Batween Onset and Deeth
disease or condition reaulting in death)	→	. 6	PAD	iral	ON TIL	ame	T					
readiting in death)		DUE TO	OR AS A CON	SEQUENCE C	in:							
A STORY OF THE STORY		b	1	ITI	1/							
Sequentially list condit if any, leading to imme	diata	DUE TO	OR AS A CO	ISEQUENCE C	n +							
cause. Entar UNDERLY CAUSE (Disease or inju		c		Den	meran							
that initiated events		DUE TO	OR AS A CO	SEQUENCE C	SPI:	CIAC	. 1		100	110		
resulting in death) LAS	"	d	Den	pure	ray	WU	WO!	r de	1900	X		
PART II. Other algnific	ent condition	na contributing to	death but n	ot resulting	In the under	lving causa o	iven In	Part i. 24e	. WAS AN	AUTOPS	24	b. WERE AUTOPSY FINDINGS
		_				, , , , , ,		- 1	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
				_				10	YES 2	□ NO		OF DEATH?
								-				1 YES 2 NO
25. WAS CASE REFERRED 1	TO MEDICAL					6. PLACE OF D	EATH (C)	book only one)				
EXAMINER?	TO MEDIONE	HOSPITAL:			OTHER:							
1 TYES 2 NO		1 Inpetient 2		28b, Til		Home 5 L Re	sidence	8 Other (Sp. 28d. OESCRIE		N HIBY O	CCUREO	
-A.s	Pending		Day, Year)		JURY	WORK?	I NO	Zou. OESCHIE	SE NOW II	NJOH! U	CCOREO	
2 Accident	investigation	28a DI ACE	OF IN HIRY — A	t home form	atreet, factory,		_ NO	201 LOCATIO	M /Christ a	and Mamb	as as Dural	Route Number,
3 Suicide 6 Homicida	Could not be datarmined		, atc. (Specify)	u nome, mim,	ationi, lactory,	OTHER			wn, State)		or or noter	House Namoer,
29a. CERTIFIER								1				
(Check only		ICIAN: To the best of										
2 MEC	DICAL EXAMIN	ER: On the basis of	examination and	d/or investigat	ion, in my opini	on, death occur	red at the	e time, data snd	place, sn	d due to	the csuse((s) and menner as stated.
29b. SIGNATURE AND TITL	E OF CERTIFIE	R	- 1		(1)	29c LICI	ENSE NU	JMBER		29d. D/	TE SIGNE	O (Month, Day, Year)
		^		01	2000		47-	136			12-	5-9(1
30. NAME AND ADDRESS O	F PERSON W	O COMPLETED CA	F DEATH	(ITBM/\$7) / for	1940//	7	1	,				/
		11/1/20	V-	NI	11/1/							
31. DATE FILED (Month, Day	Year)	分选规	A STATE	RIC Y								
DEC 9 13	74 Ju	7										

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CAISION	IL OR ATTENDING PHYSICIA!
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	HOSPITAL
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Ŧ	1. DECEDENT'S NAME (First, Middle, Last)		CERTIFI			REG. 2. DATE OF DEATH MONTH	н	3. TIME OF DEAT		
	MONTREL	L.	EVANS	3		DEC.		2120		
	000 111. 11-11	5. SEX 1 M 2 D F 6. AGE (In	yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Mg/yh, Day, Yea		BIRTHPLACE (Sinte or Fo		
CTOR	98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH									
S C	10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY									
L DIRE	10e, STREET AND NUMBER		10.017100	1 YES 2						
NERAL	1587 INGH	1910E /	VE.		2120 2120	7	11/1	OF WHAT COUNTRY?		
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DAT	2 X NO	If yes, s		ŃIC ORIGIN? (Specify an, Puarto Rican, atc. y:		RACE — American India Black, Whita, atc.		
LETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Pacondags (0-12)		16a. DECEDENT'S U (Give kind of w life. Do NOT use	ork done during m		16b, KIND OF	BUSINESS/INDUS	TRY		
COMP	17. FATHER'S NAME (First, Middle, Last)	14 22		//1	18. MOTHER'S NA	AME (First, Middle, Mai	den Surname)			
BE	188. INFORMANT'S NAME (Type/Post)	NOUR	1		1-5.18	CAT	5/	-		
2	FEFECIA PE	1	158	ADDRESS (Stoet	and Number of Rural	Fourte Number, City or	Town, State, Zip Co	M. 2120		
	20s METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remov 4 Donation 5 Dither (Specify)	al from State	E AND DATEO	F DISPOSITION (N	PX, 12	40/44 1	an DA/S	NWN M		
	21. SIGNATURE OF PHERAL SERVICE LICENSEE 22. HIGHE AND ADDRESS OF THE TAIL THE PARTY ARMY AND ADDRESS OF THE PARTY AND AD									
	23. PARTI / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or reapiratory srrest, Approximate									
RTIFICATION	resulting in death) a. MULTIPLE GUN SHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):									
듄	resulting in death) LAST									
Щ	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i						Part 1. 24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO			
S								OF DEATH?		
EDICAL C										
MEDICAL C	DID TOBACCO USE CONTRI					N				
AN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	S. PLACE OF DEATH			N D J				
SICIAN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1XXES 2 \(\text{D}\) NO	10SPITAL:	8. PLACE OF DEATH	OTHER:	ne 5 🗆 Raaldence	6 Other (Specify)				
AN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X XES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	10SPITAL: Inpetient X X ER/Outpet 2se. DATE OF INJURY 12/6/94	8. PLACE OF DEATH	OF 28c. IN.	ne 5 Raaidence	6 Other (Specify) 26d. DESCRIBE HO SUBJE(CT SHOT			
ETED BY PHYSICIAN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X XES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide S Could not be datarmined	10SPITAL: Inpatient X X ER/Outpet 28s. DATE OF INJURY	itent 3 DOA 26b. TIME 2 0 4 3	OTHER: 4 Nursing Hon OF 28c. IN. PM 1	ne 5 Raaidence	6 Other (Specify) 26d. DESCRIBE HO SUBJE(28f. LOCATION (Str	CT SHOT			
PLETED BY PHYSICIAN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X XES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	20 AT SER/Outpet 28. DATE OF INJURY 26. PLACE OF INJURY	8. PLACE OF DEATH STREE At home, farm, string STREE	OTHER: 4 Nursing Hon OF 28c. IN. WW 1 Treet, factory, office ST	iury AT PK? YES ANO a and place, and due	6 Other (Specily) 26d. DESCRIBE HO SUBJE(28f. LOCATION (Str. NORTH	CT SHOT	Rural Route Number, LONGWOOD		
COMPLETED BY PHYSICIAN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X XES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	200 AN: To the best of my knowless	8. PLACE OF DEATH STREE At home, farm, string STREE	OTHER: 4 Nursing Hon OF 28c. IN. WW 1 Treet, factory, office ST	iury AT PK? YES ANO a and place, and due	6 Other (Specity) 26d. DESCRIBE HO SUBJE(281. LOCATION (Sm. NORTH to the cause(s) and time, data and pieca	CT SHOT	Pural Route Number, LONGWOOD supe(e) and menner as st GNED (Morith, Day, Year)		
PLETED BY PHYSICIAN: MEDICAL C	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	20. Inpetient X X ER/Outpet 20. DATE OF INJURY 1 2 (Aporth) Day (Year) 20. PLACE OF INJURY 20. PLACE OF INJURY building, atc. (Specif) AN: To the best of my knowled	8. PLACE OF DEATH 1 DOA 20b. TIME 2 0 4 3 - At home, farm, st 3 STREE	OTHER: 4 Nursing Hon OF EX 1 2sc. IN, W 1 Treet, factory, office If d at the time, date , in my opinion, of	ne 5 Raaldence	6 Other (Specity) 26d. DESCRIBE HO SUBJE(281. LOCATION (Str. NORTH 2 to the cause(s) and time, data and place	CT SHOT	Pural Route Number, 'LONGWOOD suse(s) and menner as st		

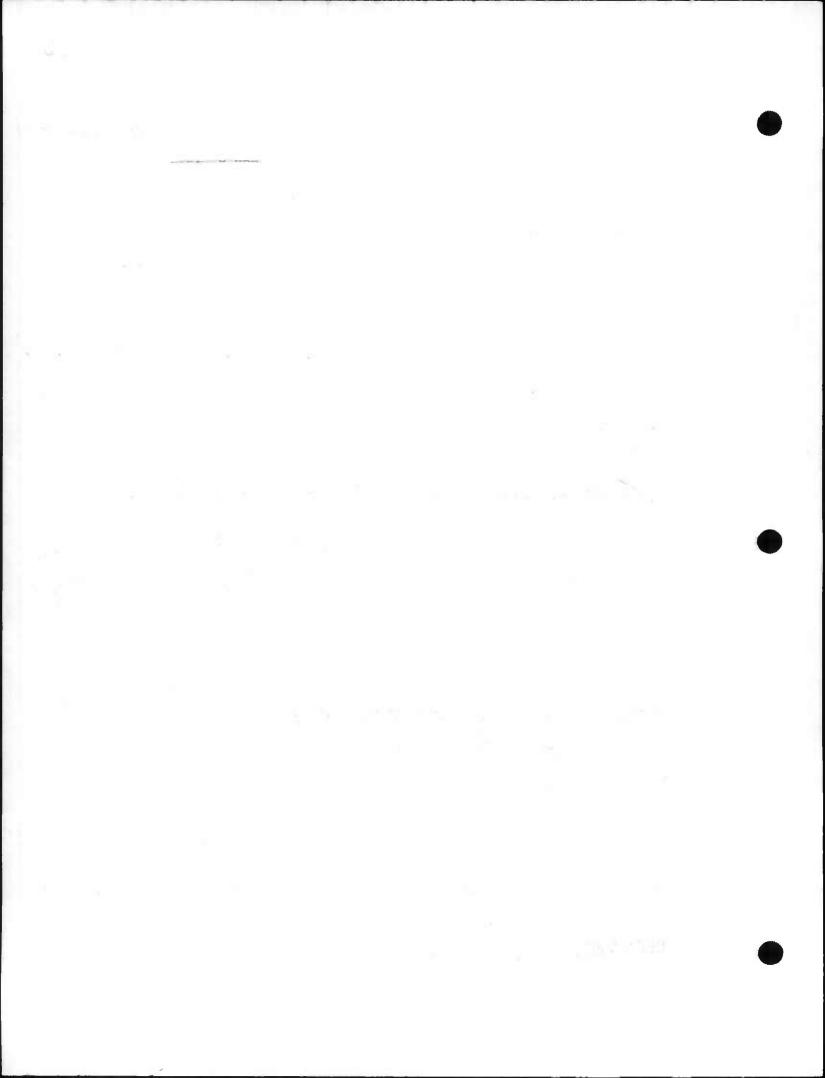
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80X 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incomplete of the continuous physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should
be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

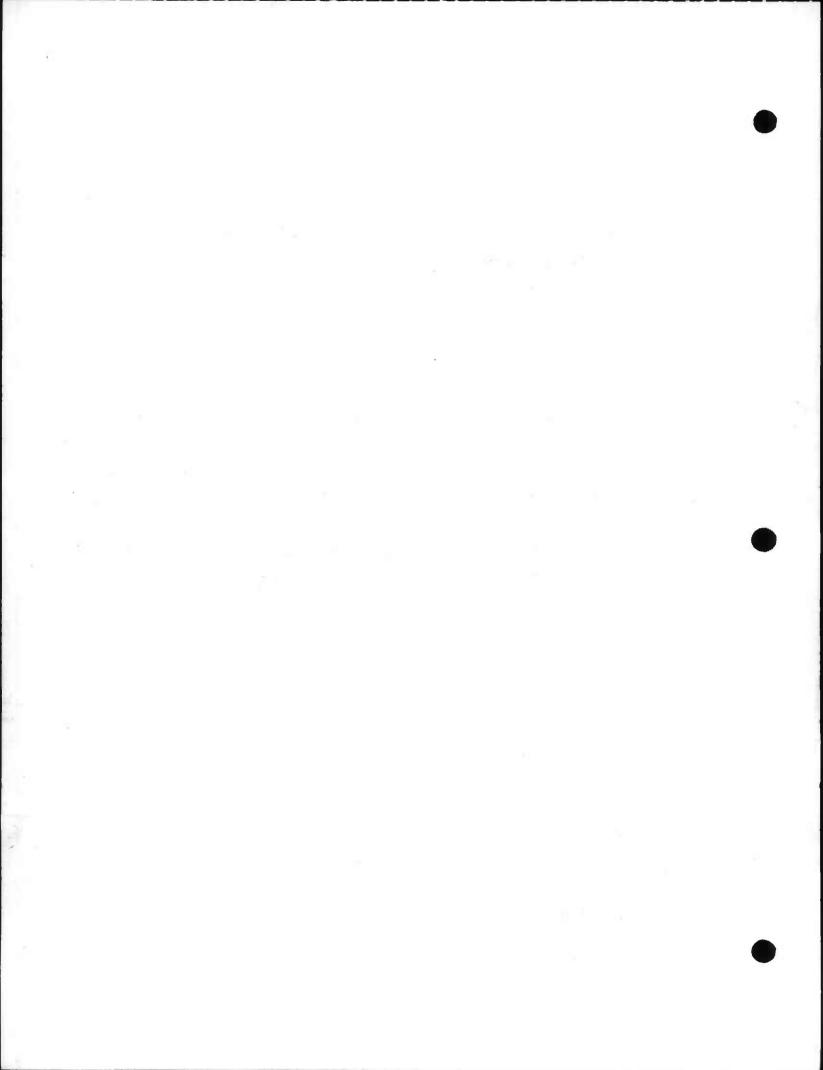
	Item # 7 Film # G 718 12-1	12-94 N.A. Pe	r funerAL	Home		34 30333			
	1 - FOR STATE REGISTRAR	TATE OF MARYLAN		ENT OF HEALTH AN	D MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)			WE OF BEAUT	2. DATE OF DEATH	3. TIME OF DEATH			
	ALARI	C FREE	EMAN		MONTH DA	PACI 1726P			
	4. SOCIAL SECURITY NUMBER 5. SE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	"	MOER 1 YEAR IF UNDER 24 HI	S. 7. DATE OF BIRTH	/9/19 8. BIRTHPLACE (State or Foreign Country)			
	339-05-8313	KM 2 □ F 80 y1	S YRS.	THS DAYS HOURS MI	Nov 9, 199	Kentucy			
	9a. FACILITY NAME (If not institution, give street an	nd number)	9b.	CITY, TOWN OR LOCATION O	F DEATH	9c. COUNTY OF DEATH			
DIRECTOR	Union Memorial Hosp RESIDENCE OF DECEDENT	oital		Baltimore, M	aryland	<u> </u>			
	Maryland			timore		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
Ä	3939 Roland Ave	enue	(apt 215) 21211		U.S.A			
5		MAS DECEDENT EVER IN U. FORCES? 1 YES			SPANIC ORIGIN? (Specify Yes ixican, Puarto Rican, etc.)	or No- 14. RACE — American Indian, Black, White, atc.			
BY	3 Widowed 4 Divorced	F YES, GIVE WAR OR DATE	S	1 TYES 2 TO NO S		Specify:			
	15. DECEDENT'S EDUCATION	4 10	a. DECEDENT'S USU	AL OCCUPATION	165 KIND OF BUIL	White			
ETE	(Specify only highest grade comple	eted)	(Give kind of work life. Do NOT use ret	done during most of working	IOB, KIND OF BOS	DINESS/INDOSTRY			
PL	Liethernary/occordary (0-12)	lege (1-4 or 5+) 4 VYS	Advertisi	ng Exec.	J. Walte	er Thompson Adv. Co			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First, Middle, Maiden	Sumame)			
BE C	Charles 0.	Freeman		Unk					
TO B	19a. INFORMANT'S NAME (Type/Print)			RESS (Street and Number of R					
F	Mr. Thomas Freeman		2 Noble	Street, West	Newton, Ma	02165			
	20a. METHOD OF DISPOSITION 1 □ Burlet 文気 Cremation 3 □ Ramoval tr	20b. PL	ACE ANO OATE OF DI	SPOSITION (Name of	OATE 20c. LO	CATION — City or Town, State			
٠.	4 Donation & Other (Specify) Green Mount Cemetery 12/10/94 Baltimore, Md								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home								
	M Glan	Dech S	h			to, Md. 21211			
NOI	23. PART I. Enter the diseases, or compliance, or heart fellure. List D IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	nly one ceuse on each	ine.	arterios		interval Batwee			
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST								
PHYSICIAN: MEDICAL	PART II. Other aignificent conditions con	AUTOPSY MED? 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO							
AN	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TIKIBUTE TO CA	HUSE OF D		40 🗆				
C	EXAMINER? HOS	SPITAL:	ОТ	26. PLACE OF OEATH	(Check only one)				
ΥS		Inpatient 2 ER/Outpatie 25s. DATE OF INJURY	ont 3 DOA 4 DOA 28b. TIME OF	Nursing Home 5 Resider		Numer company			
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	28c. INJURY AT WORK?	28d. OEŞCRIBE HOW II	NJURY OCCURED			
В	2 Accident Investigation 3 Suicide 6 Could get be	26s. PLACE OF INJURY —	At home, term, etraet	M 1 YES 2 NO	201 LOCATION (Street	and Museline on Dural Courts Number			
TED	4 Homicide 6 Could not be determined	building, etc. (Specify)	At Home, tariit, assess	, tactory, office	City or Town, State)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSICIAN:	To the best of my knowledg	ge, death occurred at	the time, data and place, and	dua to the cause(s) and man	iner as stated.			
OM						d due to the cause(s) and manner as stated.			
	29% SIGNATURE AND TITLE OF CERTIFIER	11		29c. LICENSE	NUMBER	29d. DATE SIGNED (Month, Day, Year)			
BE	Norma . No	lad has	~	(n/) $(n/)$	101	1)0- X 1010111			
TO BE	30. NAME AND ADDRESS OF PERSON WHO COM	IPLETED CAUSE OF DEATH	(ITEM 27) (Type, Prim	no DIO	portionto	bec 8 1994			
	Norman D. Hoders 31. DATE FILED (Month, Day, Year)	PLETED CAUSE OF DEATH 32. REGISTRAR'S SIGNATU Shurdson Rayle	Johns H	pkins out	potent Con	to medicine			



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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) JOHN 2. DATE OF DEATH 2-1-94 RAYMOND 3. TIME OF DEATH FISHER John -1Sher Dec 994 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 M 2 F 041 26 7356 9-5-1929 Connecticut Se. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR permit. Pages 1, 2, 3 Grove Adventist Hsp Shady Rockville Montgomery Co 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Gaithersburg Maryland Montgomery 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 7IP CODE 10g, CITIZEN OF WHAT COUNTRY? 720 Cliff Top Drive funeral director, page 5 should be detached for use as the burial-transit 20878 USA after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 K Merried BY 1 YES 2 NO Specify Specify 3 Widowed 4 Divorced 1947-49 White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET Elamentary/Secondary (0-12) College (1-4 or 5+) 12 +PhD Nuclear Physics 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumeme) Raymond Gilbert Fisher Anna Malloy notified at 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Evelyn Fisher 720 CliffTopDrive, Gaithersburg, MD20878 pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.Baltimore St, Balto, MD21201 filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween 0 IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) BEXTENSIVE OPPORTUNISTIC LUNG INFECTION DUE TO (OR AS A CONSEQUENCE OF): attending physician and completely 10 DAYS event. 2 YEARS burial, MULTIPLE MYELOMA traumatic CERTIFICATION 11 MONTHS Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING the death certificate be prior CAUSE (Disease or injury or other signed by the attending ph Health and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa reaulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? any 1 TYES 2 NO OF DEATH? shows a 1 YES 2 NO been f. of has be Dept. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, Item State this certificate HOSPITAL: OTHER: 1 | YES 2 | 0 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the g 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, with Natural 5 Pending 1 YES 2 NO BY ATTENOING After death 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 3 Suicide 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) after de 6 Could not be DIRECTOR: / COMPLETED 4 Homicide ITHE FUNERAL DIRECTORY IN THE FUNERAL DIRECTORY IN THE PORTANT: If Item 2 8 29a CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner as stated. THE HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. 295 SIGNATURE AND TITLE OF CE BE 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NORICKS 14808 31. DATE FILED (Month, Day, 32 HEGISTRAR'S SIGNATURE 9 1994 Talin Dandem-Ra DEC

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



3. TIME OF DEATH

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12:15

2. DATE OF DEATH DAY DAY DEC. 7, 1994

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

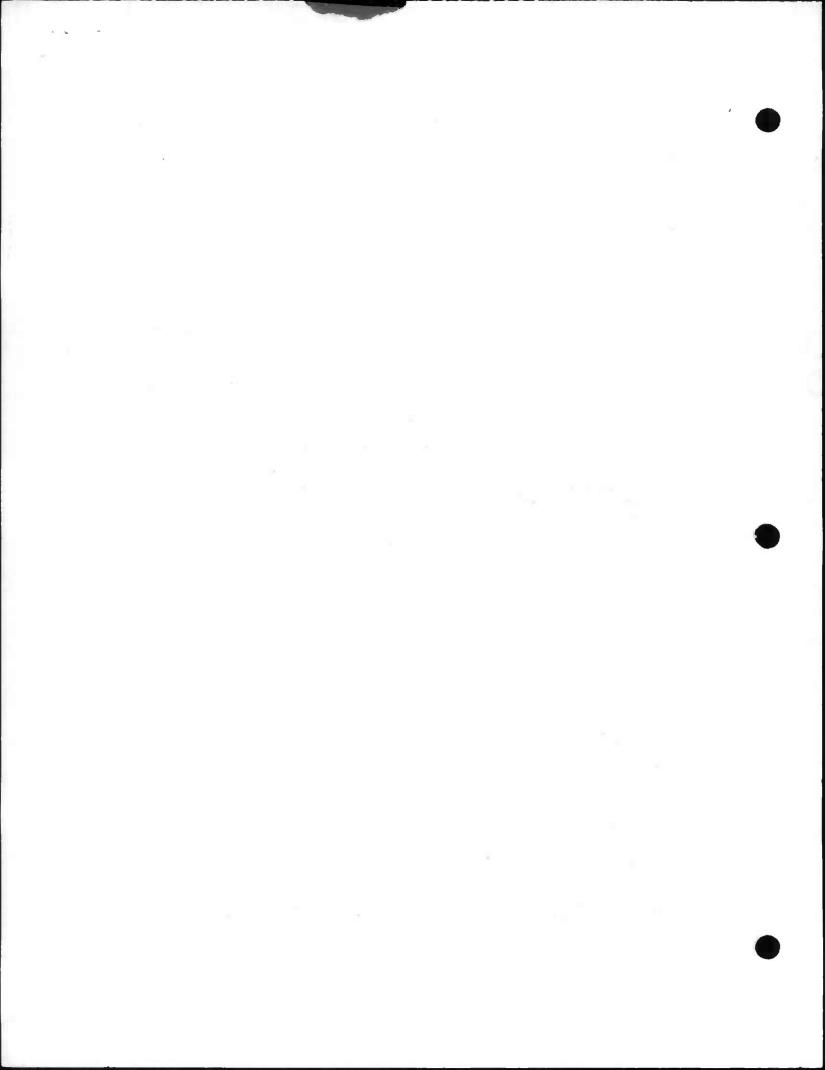
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	1	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 Y	YEAR	IF UNDER 24 HRS.		OF BIRTH			CE (State or Foreign
_	1	218-26-2289		1 🔀 M 2 🗌 F	97	YRS.	MONTHS E	DAYS	HOURS MIN.		. 27,	1897	Country)	cily
3 should	1	9a. FACILITY NAME (If not in	nstitution, give a	treet and number)			9b. CITY, TO	OWN O	OR LOCATION OF DE		. 27,		TY OF DEAT	
2.3 s	CTOR	Land Advanced Inches all the Co	0	Avenue					Baltimor	e		Ba1	timor	e City
1, 1	5	RESIDENCE OF DEC	10b. COUNT	γ		ine CIT	Y. TOWN OR	LOCAT	ION				140	T HARRIS CHEV
Pages 1,	DIRE	Maryland	Balti	•	+ **	10c, C11			timore				11.0	I. INSIDE CITY LIMITS?
mit.	AL [10e. STREET AND NUMBER		more or	Ly		-	_	ZIP CODE			10 CITIZ	EN OF WHAT	YES 2 NO
sit pe	R.	3611 Rog	ers A	venue				1	2120	7		log. Citiz	U.S.	
ling physician. the burial-transit permit.	FUNER	11. MARITAL STATUS		12. WAS DECEDER	IT EVER IN U.S.	ARMED	13. WA	S DEC	ENDENT OF HISPAN		I? (Specify Yea	or No —		American Indian.
physical		1 Never Married 2		FORCES?	YES 2	ON	If y	rea, spe	ecity Cuban, Mexica 2 NO Specify	n, Puarto I			Black, Wi	hite, atc.
attending se as the	ВУ	3 🔀 Widowed 4 🗌 Divo	orced											ite
	ETED		EDENT'S EDU ly highest grade		16a.	DECEDENT'S	work done dun			16b	KIND OF BUS	SINESS/INDU	ISTRY	
16 P	빌	Elementary/Secondary (t	0-12)	College (1-4 or 5		life. Do NOT u.	,							
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, M	ficialia (ast)		56	elf Em	ployed	d	18. MOTHER'S NA		one Ma		ontra	ctor
	N N	Antonio		errara					18. MOTHER'S NA					
5 should	00	19a. INFORMANT'S NAME (CITALA		19b. MAILING	ADDRESS (S	Street a	nd Number or Rural F		ria B		Code	
6 may be retained by ctor, page 5 should be nust be notified at	2	Mr. Antonio	Ferra	ra					Ridge Co					MD 21042
page .		200. METHOD OF DISPOSIT		50	20b. PLA	CEAND DATE	OF DISPOSITION	ON /Na	me ot	DAT			ity or Town,	
as do to		1 X Burial 2 Crematic		oval from Stata	Lorr	aine	Park M	lau	soleum	12/	12 Wo	odlaw	n, Ma	ryland
death. Page 6 may be tuneral director, page 1. Committee to the committee of the committee		21. SIGNATURE OF PUNERA	L SERVICE LIC	ENSEE	-0		22. NA	ME AN	O BYONE	CILITY	rol Di	rooto	ma T.	20
death. e funera I. examili		Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133												
ours after d d in by the or removal.		23. PART Legier the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.												
5 7 5 E		Interval Between Onaat and Death Interv												
ety fille nation,	1	disease or condition reaulting in death)	→	. Arter	1050	tow	- 0	AR	DIOUAS	WL	ar I)15 CA	185	
uted within 24 h completely filled rial. cremation, o		rouding in duality		DUE TO	(OR AS A CON	SEQUENCE O	F):							
executed and composite of the same and compo	N	Sequantially list condit	lone C	b										
cian a cor to cor to	ATIC	if any, leading to imme cause. Enter UNDERLY	dlata	DUE TO	(OR AS A CON	SEOUENCE O	F):							
e by	FIC	CAUSE (Disease or inju		cDUE TO	(OR AS A CON	SEOUENCE O	F):							
nding Hygie	CERTIFICATION	resulting in death) LAS	т	d									-	
		DADT II Other elemities	an condition		d									
E PO E	DICAL	PART II. Other algnifica			daath but no	t raaulting	in tha unde	rlying	g cauaa givan in	Part i.	24a. WAS AN PERFOR		AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO
5 E E	O.	HYPOTHY	(01) [S WY		_	_			- 1	1 [] YES 2	NO		MPLETION OF CAUSE DEATH?
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Dept 23	AN:	DID TOBACCO U		KIBUIE IO CA		ACE OF DEA			UNCERTAIN	и П				
- st et -	SICI	EXAMINER?	D INCOICE	HOSPITAL:			OTHER:				2301.2			
OH ALLENDING PHYSICIAN: DIRECTOR: After this certifica cath with the St em 28 II marked, or II	主	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM	E OF 28	_	e 5 Pealdence		CRIBE HOW II	NJURY OCCL	JRED	
ther this ce sath with the marked,	2		Pending Investigation	(Month, E	lay, Year)	INJ	INJURY WORK? M 1 YES 2 NO							
A After	8	2 0 00000	Could not be	28a. PLACE C	F INJURY — At	home, farm,	streat, factory	, office		28f. LOC	ATION (Street a	nd Number o	or Rural Route	Number,
A B R	ereo.		determined	bullaing,	atc. (Specify)					City	or Town, State)			
E E E	4	194. CERTIFIER	TIFYING PHYSI	CIAN: To the best of	my knowledge,	death occurr	ed at the time	, data	and pieca, end due	to the ceu	se(s) and man	mer se state	d.	
FUNERAL WITHIN 72 WITHIN 72	MO			R: On the basis of a										d manner ea stated.
E FUN	00	296. SIGNATURE AND TITLE	OF CERTIFIES	7. /		s: us-			29s. LICENSE NUM	BER.		29d. DATE	SIGNED (Mo	nth, Day, Year)
TO THE HOSPILL TO THE FUNERA DE filed within 7 IMPORTANT: I) BE	pan	us	my h	4	MI		- 1	1)2663	7		► /2	19190	t
	2	30. NAME AND ADDRESS OF	PENSON WH	O COMPYETED CAU	SE OF DEATH (I	TEM 27) (500)	Print)						1-1-	
		7600	884	ER D	a.	Tow	Nel		m 5	212	04			
3	1	31. DATE FILED (Month, Day,		-	R'S SIGNATURE									
/ [DEC 0 9 199	14 (6)	Muchon	Parkett									
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

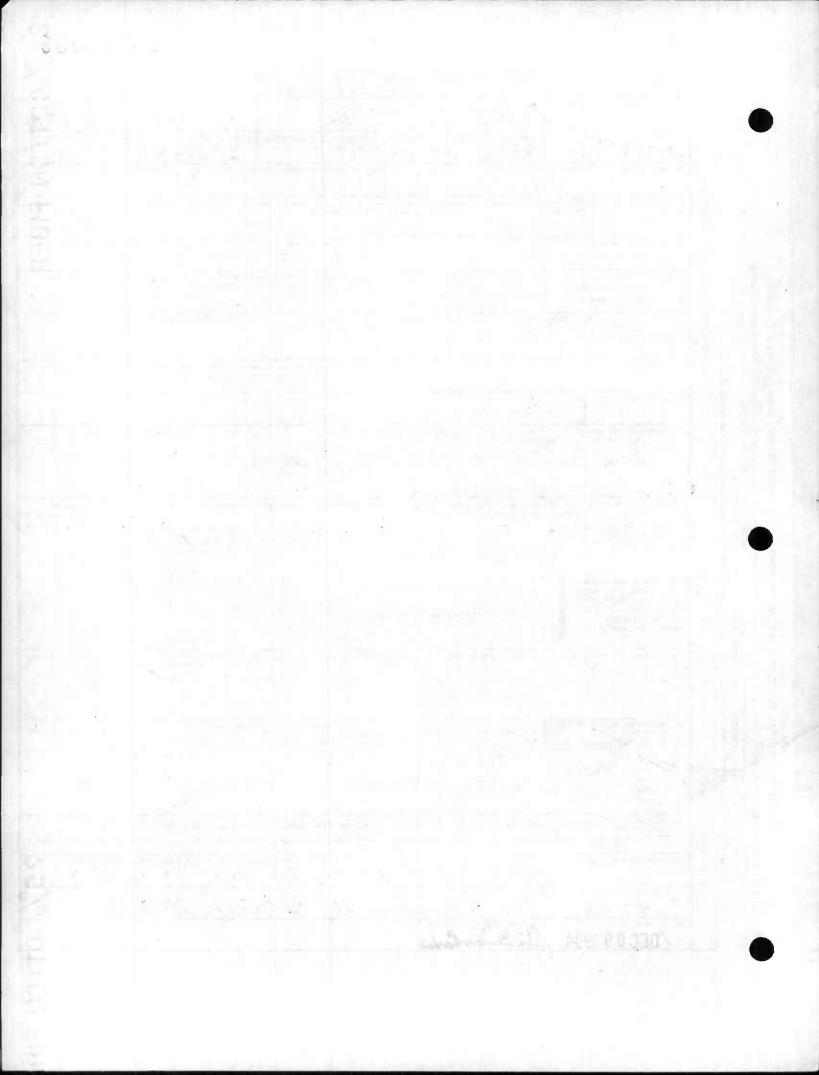
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DIVISION OF VITAL RECORDS, P.O.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			NTAL HYGIEN							
1	1. DECEDENT'S NAME (First, Middle, Last	Lobert 1	ELETC	HER	2.	DATE OF OEATH DON'TH	AY 9	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 2/7387/88	1 2 M 2 D F 5	O YRS.	HUNDER 1 YEAR DAYS	HOURS MIN.	Month, Day, Year)	44	BIRTHPLACE (State or Foreig Country)					
TOR	99. FACILITY NAME (If not institution, give street end number) CHURCH HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 9c. COUNTY OF DEATH 9c. COUNTY OF DEATH												
DIRECTOR	MARYLAND 106. COUN	тү		ALTIMO			10d						
FUNERAL	2515 FAIT AVEN	NUE		10	7. ZIP CODE 21224			JSA					
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	CENDENT OF HISPANIC Cloedify Cuben, Mexican, Post 2 NO Specify:		or No.— 14.	RACE — American Indian, Black, White, atc. Specify: WHITE					
COMPLETED	15. DECEDENT'S ED (Specify only highest gred Elementary/Secondary (0-12) 7 YEARS	OUCATION de completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of won life. Do NOT use in LONG S	k done during mo etired.)	ost of working	166. KIND OF BU							
ш	17. FATHER'S NAME (First, Middle, Last) WILBUR FLETCH	IER			18. MOTNER'S NAME (First, Middle, Maiden							
TO B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) MRS. JULIANNA FLETCHER 2515 FAIT AVENUE BALTO. MD. 21224												
	20e. METNOD OF DISPOSITION 1 Quirlei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) DATE DATE DATE DATE 20c. LOCATION - City or Town, State DATE DATE												
	22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224												
N	IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	a. List only one cause on ac	ech line.		VEL L			, Approximate interval Betwood Donset and D					
CERTIFICATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	CONSEQUENCE OF):										
MEDICAL	PART II. Other algnificant condition	ona contributing to dasth bo	ut not resulting in	tha underlyin	g ceuse given in Pari	I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH? t YES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO												
ВУ РНУ	27. MANNER OF DEATN 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO							ED					
	2 Accident investigation 3 Suicide 8 Could not be determined 4 Nomicide determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or R City or Town, State)												
	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner ee stated.												
OMPLET	(Check only	one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(e) end menner on state											
BE COMPLE	(Check only	NER: On the basic of examination					nd due to the c	GNED (Month, Day, Year)					



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Z.	ATTENDING PHYSICIAN: The I
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DIVISION OF VITAL RECORDS,	8
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		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN	-		
		1. DECEDENT'S NAME (First, Middle, Last) ETHEL		FOC	AS		2. DATE OF DEATH ON THE DEC. 6	DAY YEAR 1994	3. TIME OF DEATH	
9	200	4. SOCIAL SECURITY NUMBER 212-28-5570	5. SEX	(in yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day Year) JAN . 13,	8. BIR	THPLACE (State or Foreign	
2, 3 should	стов	90. FACILITY NAME (If not institution, give s ANNE ARUNDEL GEN RESIDENCE OF DECEDENT	·	AL	9b. CITY, TOWN (ANNAP(OR LOCATION OF D	EATH	Sc. COUNTY OF	ARUNDEL	
i. Pages 1,	DIREC	10a. STATE 10b. COUNTY	ARUNDEL	100	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
r. Insit permit.	ERAL	100. STREET AND NUMBER 642 BRETON PLACE		•	10	1. ZIP CODE 21012			F WHAT COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR C	2.X NO	If yes, sp	CENDENT OF HISPA pecify Cuban, Maxico 3 2 NO Specia	NIC ORIGIN? (Specify Year, Puerto Rican, atc.)	Bit	ACE — American Indian, ack, White, etc.	
2121	IPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+) 5+	(Give kind of life. Do NOT u	USUAL OCCUPATION Work done during mo se retired.) ARMACIST	ost of working		USINESS/INDUSTRY		
YLA by the be del	BE COMP	17. FATHER'S NAME (First, Middle, Last) DIMITRIOS		BAROT		DESPI		_	ZAPPAS	
E, MA be retain ige 5 sho										
Page 6 m director,		All Burlel 2 Cremation 3 Rem. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	ensee	b.PLACEANDDATE	HODOX CE	M. 1	2/10/94 BA			
BALTIN BALTIN hours after death. Pag ed in by the funeral di or removal. medical examiner		23. PART i. Enter the diseases, or o	Jolow E.		1050	YORK RO	AD TOWSON,	MD. 212		
within, operation, cremation,		shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on a	aach line.			Sank		Approximata interval Batween Onset and Death	
P.O. BOX 6870 th certificate be executed ending physician and com Hygiene prior to bunal, or other traumatic en	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с	A CONSEQUENCE C		hope)	Sank	Stown	•	
e death he atte Mental Jury,	AL CE	PART ii. Other algnificant condition	s contributing to death I	but not resulting	in the underlyin	g cause given in	Part I. 24s. WAS AF		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
그 등 일표 중	MEDIC						1 _ YES		COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO	
3 eg 8	PHYSICIAN:	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE C		TH (Check only one) OTHER:	UNCERTAI	N 🗆			
PHYSICIAN this certific with the the the the the the the the the t		1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 Inpatient 2 ER/Out	28b. TIA	4 Nursing Hom IE OF 28c. INJ JURY WO		8 Other (Specify) 28d. DE\$CRIBE HOW	INJURY OCCURED		
	ETED BY	2 Accident investigation 3 Suicide 8 Could not be datarmined	28e. PLACE OF INJURY building, atc. (Spe	Y — At home, farm,			28f. LOCATION (Street City or Town, State		Il Route Number,	
(Table	Demp[one) 2 MEDICAL EXAMINE	CIAN: To the best of my know						e(a) and manner as stated.	
0.0 0.0 M	TO BE	296. SIGNATURE AND TITLE OF CONTINES		\geq		29c. LICENSE NU	486	P 29d. DATE SIGNI	EQ (Monto, Day, Year)	
+		DR. VICTOR M. PLAY	VNER 1509 RI	TCHIE HI		NOLD, MD	. 21012			
		31. DATE FILEO (Month, Day, Year) DEC 0 9 1994	all dauder to	reall						

DHMH-18 Rev 1/89

BALTIMOHE, MAHYLAND 21203-3146	VSICIAN: The law requires that the death certificate be executed within proving after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - FOR STATE OF REGISTRAR	MARYLAND / DEPARTI CERTIFIC	MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest) BLANCHE E. GiL	mer-		2. DATE OF DEATH MONTH DAY	YEAR 94 10 PM						
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 TF	8. AGE (In yrs. lest birthday) III	F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-13-27	BIRTHPLACE (State or Foreign Country) M.C.						
CTOR	99. FACILITY NAME (If not institution, give etreet and number) Bon Secours Hospital RESIDENCE OF DECEDENT		a city, town on Location of De Baltimore Ci		N/A						
DIRE	Md N/A		ltimore	Love	10d. INSIDE CITY LIMITS? 1 TYPES 2 NO						
FUNERAL	331 S. Furrow StBa	ENT EVER IN U.S. ARMED	272	23 NIC ORIGIN? (Specify Yes or No	U.S.A. 14. RACE — American Indian,						
D BY	3 XWidowed 4 Divorced IF YES, GIVE	1 YES 2 NO E WAR OR DATES	If yes, specify Cuban, Mexica 1 YES 2 NO Specifi	n, Puerto Rican, etc.) y:	Black, White, etc. Specify: White						
ETE	15. DECECENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Oliege (1-4 or	Min Do NOT upo r	k done during most of working etired.)	166. KIND OF BUSINESS/IND	DUSTRY						
once. COMPL	17. FATHER'S NAME (First, Middle, Last)	110000		ME (First, Middle, Maiden Surname)							
76 111	Henry Reitterer			nie B. Boyle							
TO TO	19a. INFORMANT'S NAME (Type/Print)		DDRESS (Street and Number or Rural								
be	Connie V. Beauchamn	20b. PLACE OF DISPOSIT	cGuirk DrG		Id. 21060 City or Town, State						
Sne.	1 Donation 5 Other (Specify)	- Metro Cr	ematory.Inc.	12-8-94 Ba	alto. Md.						
examiner must be notified TO BE	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 3512 Frederick Ave. G. Truman Schwab Baltimore, Md. 21229										
event, the medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										
or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inhilated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
any Inju	PART II. Other significant conditions contributing Discusses M. el.	to death but not resulting in	the underlying ceuse given in	Part I. 24a, WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
					1 169 2 5 110						
ed, or item 23 a PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C/	neck only one)							
1 VS		2 ER/Outpatient 3 DOA 4	□ Nursing Home 5 □ Residence								
들 >	1 Natural 8 Pending (Month	or injury o, Day, Year) 286, Time (OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OC	CURED						
28 Is TED	3 Suicide 28e. PLACE	E OF INJURY — At home, farm, string, etc. (Specify)	set, fectory, office	281. LOCATION (Street and Number City or Town, State)	r or Rural Route Number,						
If ite	29s. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best one) 2 MEDICAL EXAMINER: On the best on										
IMPORTANT: O BE CO	296. SIGNATURE AND TITLE OF CERTIFIER	the 1	1) D 235		TE SIGNED (Morith, Day, Year)						
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CO	AUSE OF DEATH (ITEM 27) (Type, P.	rint)								
	31. DATE FILED (Month, Day, Year) 32. REGIST	TRAR'S AIGNATURE			- 35						

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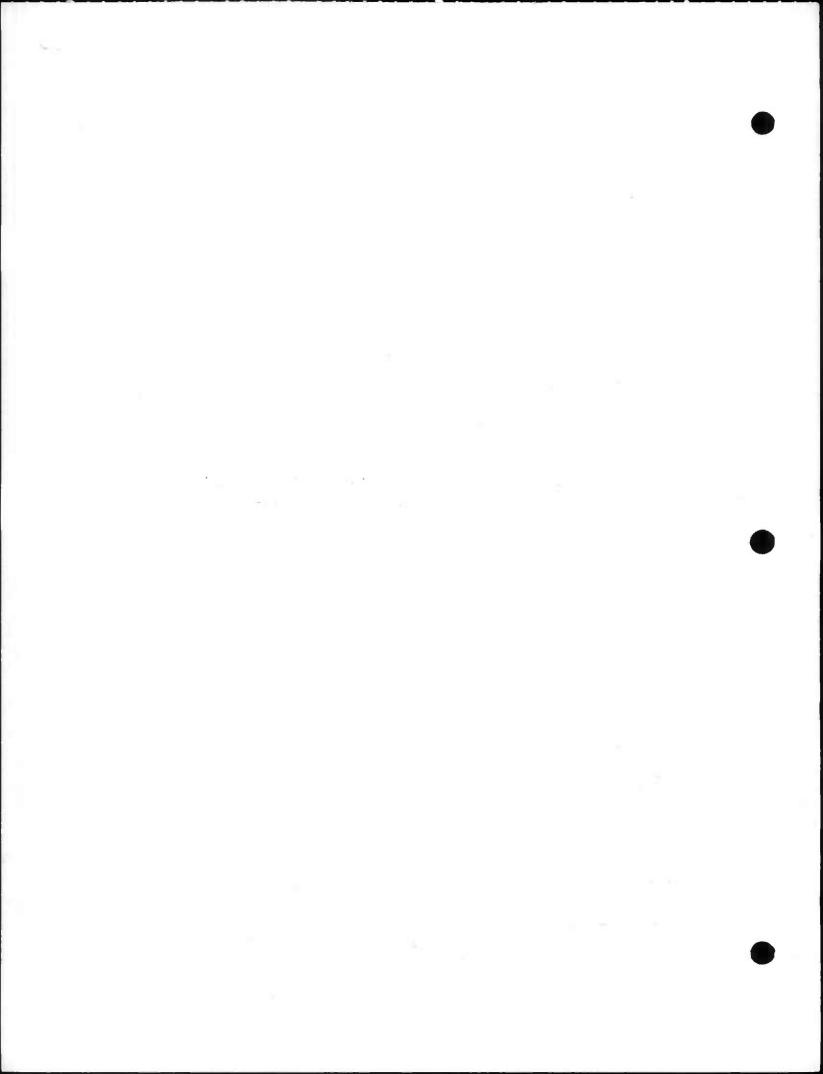
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTA	L HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Lest) A G NLS D.	Gors				2. DATE MONT	OF DEATH	AY 3	YEAR 94	3. TIME OF DEATH	м		
		SEX 6. AGE (n yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont 4 - 2	of BIRTH h, Day, Year) 6 - 15		8. BIRTHP	YLACE (State or Foreign	n		
TOR	96. FACILITY NAME (If not institution, give street and number) HOPKINS BAY VIEW BALTIMORE PESIDENCE OF DECEDENT 96. COUNTY OF DEATH												
DIRECTOR	10e. STATE MD 10b. COUNTY 323 ELRINO STRE	ET	10c. CITY	BALT					- 1	10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER 323 ELRINO STRE	ЕТ		10	21224			1	ISA	HAT COUNTRY?			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, Whita, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — Arm Black, Whita, Specify: WHITE								
COMPLETED	15. DECEDENT'S EDUCATIVE (Specify only highest grade come Elementary/Secondary (0-12) 12 YEARS	ON pleted) ollege (1-4 or 5+)	life. Do NOT us	ork done during me	st of working		RAVEL						
BE COI	17. FATHER'S NAME (First, Middle, Last) MICHAEL SWIECZKOWSKI 18. MOTHER'S NAME (First, Middle, Melden Surneme) LILLIAN NOWAK (PELOGGIA)												
10	19a. INFORMANT'S NAME (Type/Print) MR. GARFIELD PAUL GORSKI 323 ELRINOESTREET BALTO., MD. 21224												
	20e, METHOD OF DISPOSITION 1 A Burlai 2 Cremation 3 Ramoval from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of 12 - 7 BALTO. CO.												
_(21. SUBSTITUTE OF FUNERAL BEHAVIOR LICENS	es sun	shi	KACZO	ROWSKI DUNDALI	FUN				MD. 2122	22		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cerebro VASCVI & CCC dust 3 0 days												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
A	PART II. Other algnificant conditions of	ontributing to death be	ut not resulting i	n the underlyin	g cause given in	Part I.	24a. WAS AN PERFOR	MED?	-	WERE AUTOPSY FINGIN AVAILABLE PRIOR TO COMPLETION OF CAUS			
PHYSICIAN: MEDIC.	DID TOBACCO USE CONTRIB	LITE TO CAUSE O	E DEATH VE	S D NO D	LINICEDTAI		1 - YES	NO NO	1 '	OF DEATH?			
CIAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		JONCERIAII								
HYS		Pripatiant 2 ☐ ER/Outpo	ntient 3 DOA 28b, TIME	4 - Nursing Horr	e 5 🗆 Residence		SCRIBE HOW I	N RIBY OCC	UBED		_		
À	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 🗆	PK? /ES 2 NO					ucha Mumbar	_		
ETED	3 Suicide S Could not be determined 28a. PLACE OF INJURY — At home, farm, atreet, factory, office City or Rown, State) 28a. CERTIFIER 2006 CRIVING Street and Number or Rural Route City or Rown, State)										\Box		
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: O									and manner as stated	d.		
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER		P 42	MBER 757			SIGNED (Month, Day, Year)					
-		nur mo	JH		medicin	•							
	31. DATE FILED (Month, Dey, Year) DFC 0 9 1994	32. REGISTRAR'S SIGN								_			
	- 100 I June	WILLIAM CONTRACT	all							DHMH-16 Re	rv 1/89		





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		1 - STATE REGISTRAR	STATE OF MARTLA	CERTIF					TENTAL HYGIEN REG. NO	_		
_		1. DECEDENT'S NAME (First, Middle, Lest)		VIII	107	-	br tar .		2. DATE OF DEATH		3. T	IME OF DEATH
		-KENDA Kendue	GREE	N					DEC 0	YEA 1994	R	12:46A M
				n yrs. last birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)	8. BI	RTHPLAC	E (State or Foreign
P		050 00 0055	⊠ X4 2 □ F	YRS.	MONTHS	DAYS	HOURS	MIN.		BRO	ÖKLY	N, NY
2, 3 should	DIRECTOR	9e. FACILITY NAME (If not institution, give street 1000BLK RADNOR						ON OF DE		9c. COUNTY O		
←	EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN O						10d.	INSIDE CITY
permit. Pages		NEW YORK n/	a .		BROC	KLY	N				,X	LIMITS?] YES 2 NO
Olician.	FUNERAL	919 MYRTLE AVEN	-				112	06	UNITED STATES			
000	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DATE	2 V NO	11	yes, spe	ecify, Cuba	OF HISPANI In, Maxican Specify:	C ORIGIN? (Specify Yas , Puano Rican, atc.)		lack, Whi	merican Indian, ita, atc. _ACK
MIS	E	15. OECEDENT'S EDUCAT (Specify only highest grade con	(ON noleted)	18a. OECEDENT'S	work done di	CUPATIO	ON et of workir	20	16b. KIND OF BU			
Ž /	MRLET		College (1-4 or 5+)	STUD	se retired.)		ot 67 V	·9	of AR	CHITECT	OR	
YLAN d by the he d be detact	SE COM	17. FATHER'S NAME (First, Middle, Last) WILLIE GREEN						ARBAI	RE (First, Middle, Malden	Surname) BOSTIC	K	
BALTIMORE, MARYLAND er death. Page 6 may be retained by the her the tuneral director, page 5 should be detact hat. It examiner must be notified at once.	TO B	190. INFORMANT'S NAME (Type/Print) EULAH BOSTICK		19b. MAILING 919	ADDRESS MYRT				BROOKLYN,			11206
ALTIMORE, death. Page 6 may be funeral director, page of		20a. METHOD OF DISPOSITION (X) Burtal 2 □ Cremation 3 □ Removal 4 □ Donation, 5 □ Other (Specify)		PLACE AND DATE				RK		CATION — CRY O		
ALTIM death. Page funeral direct		21. SIGNATURE DE PUNERAL SERVICE LICENS		1166711111		_		SS OF FAC	ILITY			
BAL after death by the fune moval.		· Ulnessi	(cos)						FR BALT	E. NO		
in ze hours tely filled in the nation, or re-		23. PART I. Enter the diseasea, Dr comeshock, or heart fellure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	plicetions that ceused tonly one cause on se	ch line.						ratory arrest,		Approximsta interval Between Onest and Death
	Z	200 DOLLO	DUE TO (OR AS A	CONSEQUENCE O	F):		1					
	RTIFICATION	Sequentielly liet conditiona, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE O	F):							
certifica ding ph Hygiene ir other	CERTIFI	that initiated eventa reaulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):							
RDS, F at the death by the atter and Mertal y Injury, o		PART II. Other eignificant conditions c	ontributing to desth bu	it not recuiting	in the unc	derlying	g cause (given in f				E AUTOPSY FINDINGS
AL RECORDS, F he law requires that the death s has been signed by the atter e Dent. of Health and Mental m 23 shows any Injury, or	MEDICAL				_				PERFOR		OF 0	LABLE PRIOR TO PLETION OF CAUSE DEATH?
L RI law req as been bept. of		DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S N	10 2	UNC	ERTAIN			7	MES 2 NO
ITAL ITAL In The law icate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	2	8. PLACE OF OEA	TH (Check or	nly one)						
	XSI	1 TYPES 2 NO	OSPITAL: Inpetient 2 ER/Outper	tient 3 🗆 DOA	OTHER 4 Nursi		• 5 🗆 Ra	sidence (Other (Specify)	scene		
PHYSICIAN: This certific with the St	F	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)		URY		RK?	_	28d. DESCRIBE HOW I	.1 .)	
MG Willer Willer Manual	ă	2 Accident Investigation	280. PLACE OF INJURY -	1 00	3.34		/ES 2 %	PNO	Subject	Shot		
ATTEN ECTOR: 5 after n 28 ii	ETED	3 Suicide 8 Could not be detarmined	building, atc. (Specif	Street		ry, offici			281. LOCATION (Street a City or Town, State)	Radro	150004	more city
7 72 =	COMPLET		N: To the best of my knowle on the besis of examination								e(a) and	manner as stated.
TO THE HOSPITY TO THE FUNERA De filed within 7 IMPORTANT: 1	B	29b. SIGNATURE AND THE OF CERTIFIER	Oth					C.M.		29d, DATE SIGN		th, Day, Year)
P P 8 3	2	30. NAME AND ADDRESS OF PERSON WHO C	` /									
(2)		31. DATE FILED (Month, Day, Year) 1994	32. PAGISTRARY SIGNA		ı st.	ree		Dali	imore, M	ar A TqI	1U 2	21201
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remnours after death. Page 6 may be retained by the hospital or attending physician.

		FOR STATE REGISTRAR	STATE OF MAR				F HEALTH AND	ME	NTAL HYGIEN REG. NO.			
		1. DECEDENT'S NAME (First, Middle, L	ast)						DATE OF DEATH		Marka.	3. TIME OF DEATH
		EVA	HAZEL			GRES	SEM			94	YEAR	10:15 P M
		4. SOCIAL SECURITY NUMBER		GE (In yrs. la	ist birthday)	IF UNDER 1 Y			DATE OF BIRTH (Month, Day, Year)		6. BIRTH Count	IPLACE (State or Foreign
		197-20-9944	1 🗆 M 2 🖵 F	72	YAS.	MONTHS	AYS HOURS MIN.		UNE 5, 1	922		TH CAROLINA
1.	_	9a, FACILITY NAME (If not institution, g	live street and number)			9b. CITY, TO	WN OR LOCATION OF	DEATH		9c. COUN	TY OF D	EATH
	CTOH	913 LARCHMONT A	VENUE			CAPIT	OL HEIGHT	S		PRIN	ICE	GEORGES
	S I	10a. STATE 10b. CO			10c. CIT	Y, TOWH OR I	OCATION		_			10d. INSIDE CITY
- 13	DIRE	MARYLAND P	RINCE GEORGES		CA	ΡΤͲΟΤ.	HEIGHTS					LIMITS?
	AL	10e. STREET AND NUMBER	CENCE ODOTOBO		Cr	1100	101. ZIP CODE	_		10g. CIT1Z	EN OF V	WHAT COUNTRY?
1		913 LARCHMONT A	VENUE				20743				TT	SA
	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVE	ER IN U.S. A	AMED	13. WAS	DECENDENT OF HISP	ANIC O	RIGIN? (Specify Yes	or No —	14. RACI	E — American Indian,
- 1	- 41	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 Y	R OATES	NO		e, specify Cuban, Maxie YES 2 NO Spec		arto Rican, etc.)		Spec	k, White, atc.
	8	3 23 Widowed 4 Divorced					X					BLACK
1		15. DECEDENT'S (Specify only highest ((0	Give kind of v	USUAL OCCU	PATION og most of working		16b. KIND OF BUS	SINESS/INDU	USTRY	
1	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	-	e. Do NOT us							
once.	COM	12	2		REGIS	TERED		_		DICAL		
= 1		17. FATHER'S NAME (First, Middle, Last	<i>)</i>					IAME (First, Middle, Maiden	Sumame)		
	出	EUGENE 19a, INFORMANT'S NAME (Type/Print)		HAWI			INEZ					LLWOOD
notified	2 ∥	INEZ WILLIAMS		119			reet and Number or Rura					
200		20a. METHOD OF DISPOSITION					ONT AVE.	CAP			-	
TSD CL		1 Burief 2 Cremation 3(4 Donation 5 Other (Specify)	Ramoval from Stata	cemetery, cr	ematory or o	of disposition ther place) L CEM .		10		CATION — C		
		21. SIGNATURE OF FUNERAL SERVICE		ROOM) LIT		E AND ADDRESS OF F		12/94 EL	TZABE	STH,	PENNA.
		John &	JOHN E	E. DOI	LAN	RUC	K TOWSON	FUN	ERAL HOM			
D CAGNILLE		Alexander 1	Socorc				O YORK RO					4
	1	23. PART I. Enter the diseases, shock, or heart faile	or complications that cau ure. List only ona causa or	r aaah lin	aath. Do r e.	ot antar the	moda of dylng, su	ch as	cardiac or respi	ratory arre	est,	Approximata Interval Batween
	İ	IMMEDIATE CAUSE (Final disease or condition	9,,,,,	1	- 0		- Ca.	1		11 .		Prestland Death
		resulting in death)	Jellere	L.	SON	enu	o an	K	amakah a	my		Moderned
	ı		DUE TO (OR #	AS A CONSE	OUENCE OF	10.	Non		111			Dal Oa
ATION	5	Sequantially list conditions,	Dual to con A	AR'Y CONFE	1 3u	tem	tarea	1	5 4			Processor
E	₹	if any, leading to immediate cause. Enter UNDERLYING	Sigh	3 4	LI A	Su	Mysson	0				
8	를	CAUSE (Disesse or Injury that initiated evants	ROJ OT SUG /	S A CONSE	MENCE OF	3: -4	W. CONV	4	200			i
CERTICICATION		resulting in death) LAST	. Hran	Lens	me	Ca	Adionas	cu)	las Dis	Seano)	1
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3	₹	PART II. Other significant cond	tions contributing to deat	h but not	rasuiting l	n tha unde	lying cause given in	n Part	I. 24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
/Cicia	5								1 YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
3	Σ∥											1 YES 2 NO
DUVEICIANI	ž	DID TOBACCO USE CO						IN []			
NAIOIS	3	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	26. PLA	CE OF OEAT	H (Check only OTHER:	one)					
2	2	1 YES 2 NO	1 fnpatient 2 ER/C			4 - Nursing	Home 5 - Rasidence	-				
		27. MANNER OF DEATH 1 Natural 5 Pending	28a. OATE OF INJUI (Month, Day, Yea		28b. TIM INJ	URY	WORK?	280	. DESCRIBE HOW II	NJURY OCC	UREO	
2	ā	2 Accident Investigati		I I I I I I I I I I I I I I I I I I I			YES 2 NO	1_				
6	3	3 Suicide 6 Could not		Specify)	ome, farm, a	treet, factory,	office	261	City or Town, State)	ind Number o	or Rural F	Route Number,
L	. -	AD. CERTIFIED										
Ta IdMO			HYSICIAN: To the best of my kr									
Ş	3 1	2 [] MEDICAL EXA	MINER: On the basis of exemina	etion and/or	investigatio	n, in my opini	on, death occured at th	e time	data and place, and	d due to the	Cause(a) and manner as stated.
o ar c		295. THE OF CENT	Maria Constitution	a 20 1	NA	1	29c. LICENSE NU	JMBER		29d. PATE	SIGNED	(Moons Day Year)
0		Janophu	MARINE	9	TIVIT)				16	2/2	174
15		30. NAME AND AGORESS OF PERSON				,			1470			
		DR. JOSEPH ROBIN				VAY MI	TCHELLVIL	ĿΕ,	MD.			
		DEC 0 9 1994	32. AEGISTRAR'S S	SNATORE	8							
	_][DEC - 9 1994	7									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIFI	CATE C	F DEATH	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last) THOMAS EDWARD GROGAN 2. DATE OF OEATH MONTH DEC. 8 1994											
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest birthday)	IF UNDER 1 YEA	IF UNDER 24 HRS.	7. DATE OF BIRTH		7;00 P M				
	216-09-8198	1 X M 2 - F	98 YAS.	MONTHS DAY		(Month, Day, Year) 3-6-1896	1	Country) Md •				
	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOV	N OR LOCATION OF DE	EATH	9c. COUNTY					
DIRECTOR	6917 Broenin	g Rd		Dui	ndalk		Ba1t	imore				
D D												
E .	Md. Ba	ltimore		Dui	ndalk			1 TYES 2 X NO				
	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
ER	6917 Broenin				21222		1	USA				
FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EV FORCES? 1	ER IN U.S. ARMED		DECENDENT OF HISPAN specify_Cuben, Mexica	NIC ORIGIN? (Specify Yes	or No- 14.	RACE American Indian, Black, White, etc.				
В	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	1 🗆 '	rES 2 NO Specif	y:		Specify: White				
	15. DECEDENT'S EDI (Specify only highest grad	JCATION e. completedi	18e. DECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BUS	I SINESS/INDUST	RY				
COMPLETED	Elamentary/Secondary (0-12)	College (1-4 or 5+)			most of working							
MP	8		Dril1	Pres		Manuf		ing				
_	17. FATHER'S NAME (First, Middle, Last) Thomas E. G1					ME (First, Middle, Meiden n Brannan						
BE	19a, INFORMANT'S NAME (Type/Print)	Ogan	19b. MAILING	ADDRESS (Stre		Route Number, City or Town		da)				
6	Loretta McGi	ath			ard Driv			Md 21222				
	20a. METHOD OF DISPOSITION 1 X Burlal 2 □ Cremetion 3 □ Rer	normi form State	20b. PLACE AND DATE O	FDISPOSITION	(Neme of			or Town, State				
	4 Donetion 5 Other (Specify)		Parkwood	_		ルル Bal	timor	e,Md.				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Du											
	Conthony	Colt Con	rnelly	71	10 Sol1e	ers Pt Rd	21	222				
	23. PART i. Enter the diseases, or complications that caused the death po not enter the mode of dying, such as cardiec or respiratory errest, abook, or haert feiture. List only one cause on each line. Approximate interval Between											
	iMMEDIATE CAUSE (Final disease or condition		V					Onaat and Death				
	reaulting in death)	a. UVOSCI DUE TO (OF	AS A CONSEQUENCE OF)·								
z	- uvinary obstruction.											
9	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE OF):								
CERTIFICATION	CAUSE (Disease or Injury	C	AS A CONSEQUENCE OF									
	that initiated avents resulting in death) LAST		AS A CONSECUENCE OF):								
		d										
DICAL	PART II. Other aignificant condition	ns contributing to dea	th but not resulting in	n the underly	/ing causa givan in	Pert I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
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Σ	DID TOBACCO USE CONT	DIRLITE TO CALIS	E OF DEATH VE		UNCERTAIN			1 TYES 2 NO				
Ž	25. WAS CASE REFERRED TO MEDICAL	LIBOTE TO CAUS	28. PLACE OF DEAT			4 🗓 📗						
3	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/	Outpatient 3 DOA	OTHER:	Iome 5 🗆 Residence	8 Other (Specify)						
PHYSICIAN: M	27. MANNER OF DEATH	28e. DATE OF INJU	JRY 28b, TIME	OF 28c.	INJURY AT WORK?	28d. DESCRIBE HOW IF	JURY OCCUR	ED				
λ	1 Natural 5 Pending 2 Accident Investigation			M 1 [YES 2 NO							
3	3 Suicida 8 Could not be 4 Homicide determined	building, atc.	JURY — At home, farm, st (Specify)	treet, factory, o	ffica	281. LOCATION (Street a City or Town, State)	nd Number or F	lural Route Number,				
1 200 CEDTIFIED												
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner as stated. Comparison one												
	29b. SIGNATURE AND TITLE OF CERTIFIE			ELON	29c. LICENSE NUM			GNED (Month, Day, Year)				
2	nn	-05			D (11	955	▶ / C	9 9 U				
2	30. NAME AND ADDRESS OF PERSON WI		F DEATH (ITEM 27) (Type,	Print)	1 771	J J	-	- 1 7				
- 1		LON, M	D. JH	GC	BAYL	ILEW						
10	21 DATE SHED (Month One Word)											
	DEC 0 9 1994	July of Lundson										

...

8. BIRTHPLACE (State or

4.5.

10g. CITIZEN OF WHAT COUNTRY?

9c. COUNTY OF DEATH

3. TIME OF DEATH

10d. INSIDE CITY

Specify: Black

Approximate interval Between

Onset and Death

WE MONTH

3-4NKS

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

OF DEATH?

Ecomber 2

1 YES 2 NO

11:150

REG NO

2. DATE OF DEATH

1. DECEDENT'S NAME (First Middle, Lest) DEC. 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (in yrs. lest birthday, 1 M 2 - F DAYS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH Specialty DIRECTOR TIMOYE RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 1+mORE 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 611 S. CHARLES the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or remoral. ours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 Never Married 2 Married 1 YES 2 NO Specify ВУ 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) y/Secondary (0-12) GrAGE FARMER FAR 17. FATHER'S NAME (First, Middle, Last) 듅 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number 9 Wilso LAYFAU pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE DERRICK C. JONES or removal. the medical 23. PART i. Enter the diseeses, or complicatione Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart failure. Liet only one case on each line. **IMMEDIATE CAUSE (Fine)** DUE TO (OR AS A CONSEQUENCE OF): RENAL disease or condition resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, requires that the death certificate be executed with SEPSIS traumatic CERTIFICATION Sequentially llet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in death) LAST 0 any Injury, PART ii. Other aignificent conditione contributing to death but not reculting in the underlying ceuse given in Part i. MEDICAL 24e. WAS AN AUTOPSY ABSCESS RESPIRATORY signed by t Health and 1 TES 2 NO item 23 shows certificate has been h the State Dept. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO IN UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one The **EXAMINER?** SPITAL: OTHER: 1 YES 2 NO DR ATTENDING PHYSICIAN: Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY this c 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural 5 Pending 1 YES 2 NO В After death Investigation 2 Accident 28e. PLACE OF INJURY - At home, farm, street, factory, office 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED DIRECTOR: / 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated. TO THE HOSPITAL ITO THE FUNERAL DE FIEED WITHIN 72 h (Check only one) of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On 291 SHATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. WALLACE 611 S.CHAMUES 51. July Ductor hardall

DFC 0 9 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

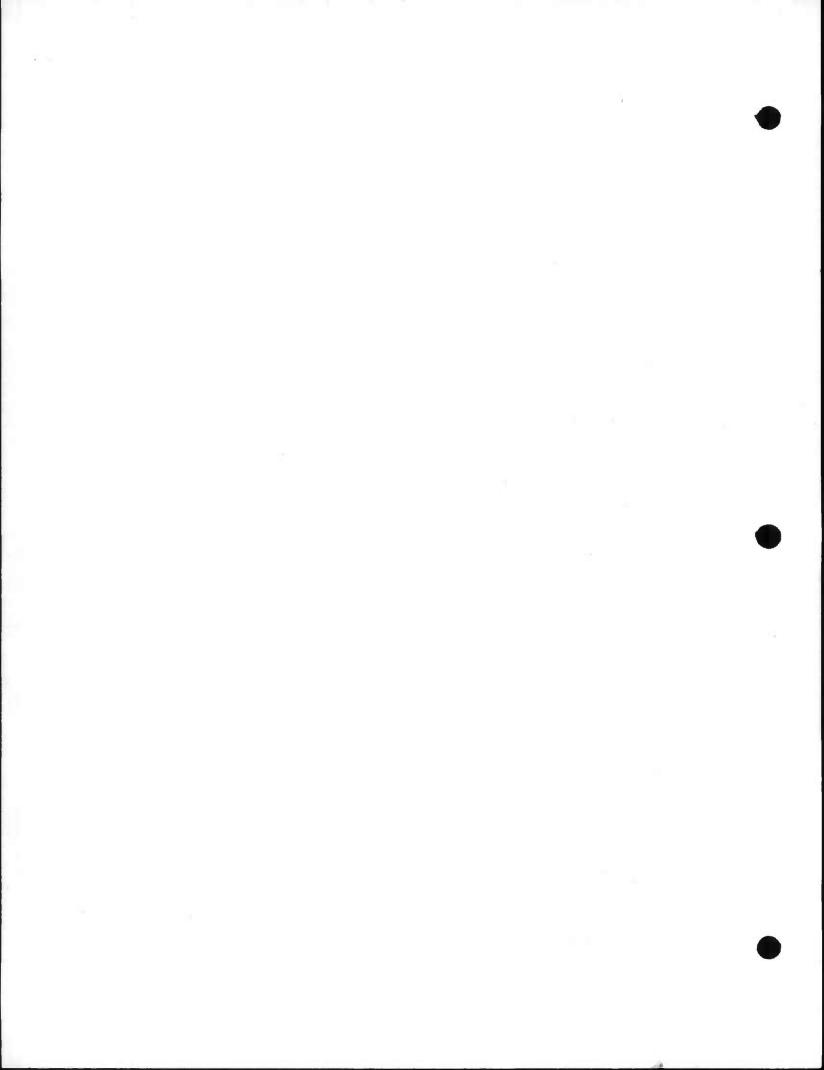
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH
REG. NO.

	REGISTRAR		CE	ERITE	ICATE	OF	DEATH		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH SOUTH DAY YEAR 3. TIME OF DEATH											
	EDDIE				HO)WA	RD	DEC			YEAR	12:44 PM	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1 Y		IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTI	IPLACE (State or Foreign	
	262-18-6579 9a. FACILITY NAME (If not institution, give st	1 🛭 M 2 🗆 F	76	YRS.		MYS	HOURS MIN.	Jan	h, Day, Year)	18 S	out	n Carolina	
DIRECTOR	3514 HOLMES AV		96. CITY, TOWN OR LOCATION OF DEATH BAltimore 90. County of Death										
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY												
H				10c. CIT	Y, TOWN OR L			0				10d, INSIDE CITY LIMITS?	
-	MD 100, STREET AND NUMBER		-	<u> </u>	B	7	timore	U1t	. У			XX YES 2 NO	
FUNERAL	3514 Holmes Ave					101.	ZIP CODE 212	17		10g. CITIZ	US A	WHAT COUNTRY?	
F	11. MARITAL STATUS	12. WAS DECEDENT FORCES?	EVER IN U.S. AR	MED	13. WAS	S DECE	ENDENT OF HISPA cify Cuban, Maxic	NIC ORIGIN	17 (Specify Yes	or No-	14. RACI	E — American Indian, k, White, atc.	
ВУ	1 Never Married 2 Married 3 Never Married 4 Divorced	IF YES, GIVE W	AR OR DATES				2 XNO Specif		rican, atc.)		Spec		
ED	15. DECEDENT'S EOUC (Specify only highest grade	ATION	18a. DE	CEDENT'S	USUAL OCCU	JPATIO	N	16b	. KIND OF BU	SINESS/IND	USTRY	DIGCK	
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	Do NOT us	vork done duri e retired.)	ng mos	t of working						
MP	7			Aut	o Meh	ıha	nic		Auto	Ind	lust	try	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (First, I	Middle, Maiden	Sumame)			
BE (Willie Howard	<u> </u>					Etta						
6	18a. INFORMANT'S NAME (Type/Print)						nd Number or Rural					150	
	Wilsonia Whitfi	.eld					d Ct.	Virgi	nia Bea	ch, VA	234	+56	
	20%, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION /Name of OATE 20c, LOCATION — City or												
	Commented 2 Crammation 3 Removal from State Comment Comment												
	· N.E.L.	w.M	1		Un	nit	y Fune	ral				un 01001	
	23. PART I. Enter the dieeeses, or c	omplications that	coursed the de	eth Do r	1 U) 8 • mad	W. Nor	th A	ve.	Balt	.0,	MD 21201	
	ahock, or hast failure. List only one cades on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):												
CERTIFICATION	Sequentisity liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
ᇤ	resulting in deeth) LAST	l											
	PART II. Other significant conditions	contributing to	leeth but not re	equiting	n the under	rivino	Cause chan in	Part I	740 1000 000	ALITOPAY	1 000	WERE ALTRACOL FROM	
EDICAL				- suring I	the under	riying	cause given in	rari I.	24a. WAS AN PERFOR	MED?	246	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH?	
Σ												1 TYES 2 NO	
ž	DID TOBACCO USE CONTR	IBUTE TO CAL	JSE OF DEAT	TH YE	S NC		UNCERTAI	N M					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF OEAT	H (Check only	one)					_		
YSI	1 XYES 2 NO	1 🗆 Inpetient 2 🗀		□ DOA	OTHER:	Home	5 XRasidenca	a 🗆 Othe	r (Specify)				
PH	27. MANNED OF DEATH 1 Natural 5 Pending	28a. DATE OF I (Month, De	NJURY y, Year)	28b. TIM	E OF 28	c. INJU WOR	IRY AT	28d. DES	CRIBE HOW I	NJURY OCC	URED		
B≺	1 Matural 5 Pending 2 Accident Investigation						ES 2 NO			_			
	3 Suicida a Could not be 4 Homicide determined	28e. PLACE OF building, a	INJURY — At hor itc. (Specify)	me, farm, a	treat, factory,	offica		28f. LOC. City	ATION (Street a or Town, State)	and Number o	or Rurai F	Route Number,	
COMPLETED		CIAN: To the best of r											
ő	2 X MEDICAL EXAMINER	t: On the basis of axi	mination and/or k	nveatigatio	n, in my opini	lon, de	ath occured at the	time, deta	and place, an	d due to the	cause(s) and manner as stated.	
BEO	29b. SIGNATUME AND TITLE OF CERTIFIER	00.				T	29c, LICENSE NUI	MBER		29d. OATE	DATE SIGNED (Month, Day, Year)		
	Dennis (Quite	M				O.C.M.	E.		DE	C.0	4,1994	
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUS											
				Pen	n St	ree	et, Bal	time	ore,	Mary	lan	d 21201	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAF	'S SIGNATURE										



		ERTIFIC	ALE OF	DEATH	RI	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) HOMJan	792	Ho11		2. DATE OF D	EATH 12-1-	94 3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 2 3 7 5 4 1 6 0 7 1 M 2	YRS. MO	UNDER 1 YEAR WITHS DAYS	IF UNDER 24 HRS. HOURS MIN.		7 ¹⁰ 1937	BIRTHPLACE (State or Foreign Country)			
CTOR	9a. FACILITY NAME (# not institution, give street and number) University Hospital RESIDENCE OF DECEDENT	96.		or Location of DE ltimore	ATH	9c. COUNTY OF DEATH 11 A				
DIREC	10s. STATE 10b. COUNTY Maryland	1	own on Loca		10d. INSIDE CITY LIMITS?					
	100. STREET AND NUMBER	1 0		OT E	- 10	10g. CITIZ	1 YES 2 NO			
FUNERAL	11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. A	DMED	L 40 UMO OF	CENDENT OF HISPAN		11.35				
B	1 Never Married 2 Merried 3 Wildowed 4 Divorced FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		if yes, s	pecify Cuban, Maxica S 2 NO Specify	n, Puarto Rican		14. RACE — American Indian, Black, White, etc. Specify: Black			
LETED	(Specify only highest grade completed)	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY								
COMPLET	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Malden Surname)								
TO BE	19a. INFORMANT'S NAME (Type/Print)	9b. MAILING ADI	DRESS (Street	and Number or Rural I	Soute Number, C	ity or Town, State, Zip	Code)			
1031		AND DATE OF DI		leme of	DATE	20c. LOCATION (City or Town, State			
examiner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wad	e,Dir		AND ADDRESS OF FA	0 0		tomy Board ,MD21201			
ry, or other traumatic event, the medical	anock, or heert fellure. List only one cause on each line. Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Later of the total conditions of the conditions of t									
51 .	PART II. Other significent conditions contributing to death but not	resulting in ti	he underlyir	ng ceuse given in	Part I, 24a.	WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDIN			
shows any inj	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO									
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	01		PLACE OF DEATH (Ch						
PHY	1 YES 2 PRO 1 Impetient 2 ER/Outpetient 27. MANNER OF DEATH 1 Testurel 5 Pending Investigation	3 DOA 4 DOA 14 DOA 1NJURY	28c. IN	me 5 Residence IJURY AT ORK? YES 2 NO		ecify) E HOW INJURY OCC	SURED			
TED	2 Accident investigation 3 Suicide 8 Could not ba 4 Homicide detarmined 28s. PLACE OF INJURY — At h	ioma, farm, stree	t, factory, offi	Ica	281. LOCATION		or Rural Route Number,			
M M	29a. CERTIFIER (Check only one) 1 ERTIFYING PHYSICIAN: To the best of my knowledga, done) 2 ΜΕDICAL EXAMINER: On the basis of axemination and/or									
O BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI	ABER	29d. DATE	SIGNED (Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITI			St (3011	me	1046			
	DEC 9 1994 Juliu Sendam Rank	all.								

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Taw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

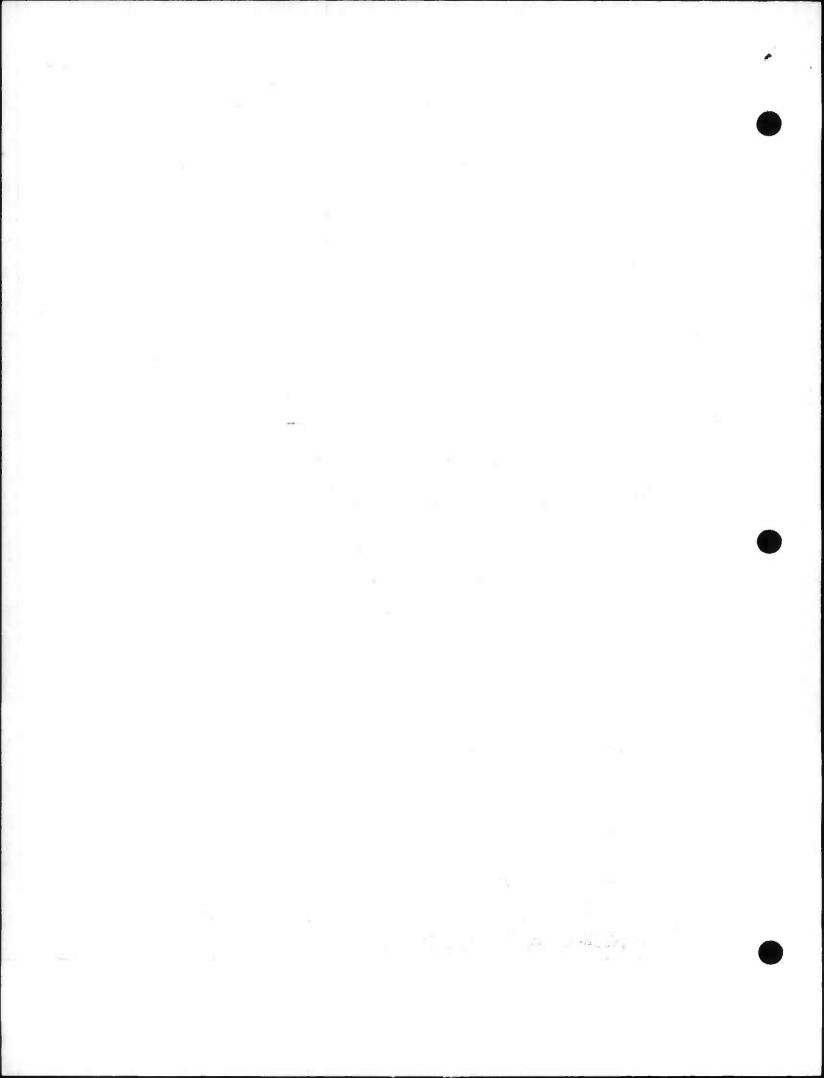
TO BE COMPLETED BY FUNERAL DIRECTOR IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ITEM: 19b, PER F.H. FI	LM G-718 12	/9/94 t.t					91	36	5546
1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND / DEPAR CERTIF	RTMENT	OF HEAL	JH AND I	MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Last)	·					2. DATE OF DEATH		13.	TIME OF DEATH
HOWARD	MALOKIC	175				MONTH DA	Y	YEAR	0390
4. SOCIAL SECURITY NUMBER	1113/7 11/	. AGE (In yrs. last birthday)	IF UNDER t	VEAD IE I	NOER 24 HRS.	7. DATE OF BIRTH	-	A PHOTUBLA	CE (State or Foreign
215-01-5340	1 ☑ M 2 ☐ F			DAYS HOU	-	(Month, Day, Year)			
9a. FACILITY NAME (If not institution, give st		84 YRS.	41 0/27/			MARCH 14, 19			DRE, MD.
	•				CATION OF DE	ATH	9c. COUN	TY OF DEATH	1
GOOD SAMARITAN HOSPI	IAL		BALTI	MORE					
10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR	LOCATION				100	I. INSIDE CITY
MARYLAND BALTIMO	RE								LIMITS?
10e. STREET AND NUMBER	111			101. ZIP (CODE		10- CITI	ZEN OF WHAT	
ALL THOUSE CENTROLOGY									COUNTRY
9015 WOOD PARK COURT 11. MARITAL STATUS	12. WAS DECEDENT	PUED IN II O ADMED		212			USA		
1 Never Married 2 Married	FORCES? 1	YES 2XXNO	lf :	yes, specify (Cuban, Maxica	IC ORIGIN? (Specify Yes n, Puerlo Rican, etc.)	or No-	14. RACE — / Black, Wr	American Indian, hita, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAF	R OR DATES	1 [☐ YES 2 X	NO Specify			Specify:	
15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S	I I CO	CUBATION	-			WHITE	
(Specify only highest grade	completed)	(Give kind of	work done du	uring most of w	vorking	16b. KIND OF BUS	INESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)		se reared.)			OF AL THOT	0.0 TO (
8		SALESMAN				SEALTEST I			
17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maiden			
WILLIAM HAWKINS						REIMENSCHNEI			
19a. INFORMANT'S NAME (Type/Print)						Route Number, City or Town			
MARIE HAWKINS 9015 WOOD PARK COURT V BALTIMORE, MARYLAND 21234									
20a. METHOD OF DISPOSITION 1 [X] Burial 2 Cremation 3 Remo	wal from State	20b. PLACE AND DATE					CATION -	City or Town,	State
4 Donation 5 Other (Specify)		PARKWOOD CE	METERY	DECEME	BER 5, 1	.994 BALTII	MORE,	MARYLAN	D
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
Massaho Fund	ral Har	m. Inc.	740	M BELAT	TR ROAD	IOME, INC. BALTIMORE, M	ARYI AN	D 21236	
23. PART I. Enter the diseases, or cahock, or heart failure.	omplications that of	caused the death. Do	not anter t	ha moda of	dying, aucl	n as cardiac or reapi	retory arr	est,	Approximate
IMMEDIATE CAUSE (Final	List Only Ona Cause	on auch ma.		1				į	intarval Between Onset and Daath
disease or condition resulting in death)	60	don't	has	-				į	12000
resulting in dauth)	DUE TO (O	AS A CONSEQUENCE O	F):						. 2000
	A4	Lenscle.	iea					j	- 1
Sequantially list conditions,	DUE TO (O	R AS A ODNSEQUENCE O	9 7 1)						
if any, leading to immediate cause. Enter UNDERLYING	Ath	DI KL	Mes	- nf				j	
CAUSE (Disease or injury that initiated evants	DUE TO (O	R AS A CONSEQUENCE O	D:						
resulting in death) LAST	1-10	8	•					1	
	3								
PART if. Other algorificant condition	a contributing to de	eath but not reauiting	in the und	larlying cau	aa given in				RE AUTOPSY FINDINGS
						PERFOR		COR	ILABLE PRIOR TO WPLETION DF CAUSE
									DEATH?
								1 '	YES 2 NO
25. WAS CASE REFERRED TO MEDICAL				28 PLACE (OF DEATH (Che	ack ack acci			
EXAMINER?	HOSPITAL:		OTHER:	:					
1 YES 2 NATO		R/Outpetlant 3 DOA				8 Other (Specify)			
1 Natural 5 Pending	28a. DATE OF IN (Month, Day,		JURY 2	28c. INJURY A WORK?		28d. DEŞCRIBE HOW II	NJURY OCC	URED	
2 Accident Investigation				t TYES	2 NO				
3 Suicide 6 Could not be determined	28a. PLACE OF I building, at	INJURY — At home, farm, c. (Specify)	street, factor	ry, offica		28f. LOCATION (Street a City or Town, State)	nd Number	or Rural Route	Number,
29a. CERTIFIER 1 4 CERTIFYING PHYSIC	CIAN: To the heat of -	y knowledge death accord	and and all and						
		y knowledge, death occurr mination and/or investigation							t menner as stated
296. SIGNASORE AND THE OF CENTIFIES			, , ,						
1114 11	1			29c.	LICENSE NUM	IRFH	29d. DATE	E SIGNED (Mor	nth, Day, Year)

TRANK SIGNATURE

281 OHMH-16 Rev 1/89

Suite auson ZI



3. TIME OF DEATN

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

USA

1 X YES 2 NO

White

Approximate intervel Between

24b. WERE AUTOPSY FINDINGS

AMAILABLE PRIOR TO

OF DEATH? 1 TYES 2 T NO

Ste 215, Glen Burnie, MD 21061

COMPLETION OF CAUSE

Onset and Death

0730

AM

REG. NO

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTN DAY 6 1994 December Ethel Harris 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH
Jan. 23, 1895

8. BIRTHPLACE (State or Foreign Country)
South Carolina IF UNDER 1 YEAR | IF UNDER 24 HRS. 579-68-2987 MONTHS DAYS HOURS MIN 1 M 2 K F 99 VRS Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH Arundel Hospital Association DIRECTOR A.A.County North Glen Burnie 10a. STATE 10c. CITY, TOWN OR LOCATION MD Anne Arundel Millersville permit. 1 FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 729 Lumbee Court 21108 burial-transit Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuban, Maxican, Puarto Rican, atc.)
1 ☐ YES 2 ▼ NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 1 Never Married 2 Married IF YES, GIVE WAR OR DATES В use as the 3 Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY COMPLET Q Elementary/Secondary (0-12) College (1-4 or 5+) page 5 should be detached 8 Homemaker Own Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) John T. Freeman Ħ Ella DuTart notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Harris 729 Lumbee Court, Millersville, MD 21108 e 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1X Buriel 2 Cremetion 3 Removal from State uneral director, National Mem. Park Cem. 4 Donation \$ Other (Specify) Falls Church, medical examiner 21. SIGNATURE OF PURSUAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ours after death. Hardesty Funeral Home, P.A. Valuek lan 12 Ridgely Ave. Annapolis, MD 21401 completely filled in by the 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Final the cremation, disease or condition event, resulting in deeth) DIVISION OF VITAL RECORDS, P.O. BOX 68760, prior to burial, traumatic CERTIFICATION and Sequentially list conditione, If any, leading to immediate the attending physician Mental Hygiene prior to ceuse. Enter UNDERLYING CAUSE (Disease Dr injury or other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the amy 1 YES 2 DINO shows ? has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) this certificate h with the State [HOSPITAL OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, streat, factory, offica building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 COMPLETED 8 Could not be 4 Homicide 28 datarmined Item 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(a) and manner as stated. TO THE HOSPITAL ITO THE FUNERAL CE DE filed within 72 h FUNERAL ((Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piecs, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) deel

300 Hospital Dr

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

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David Schwartz, M.D.

3 REGISTRAR'S GN TUR

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

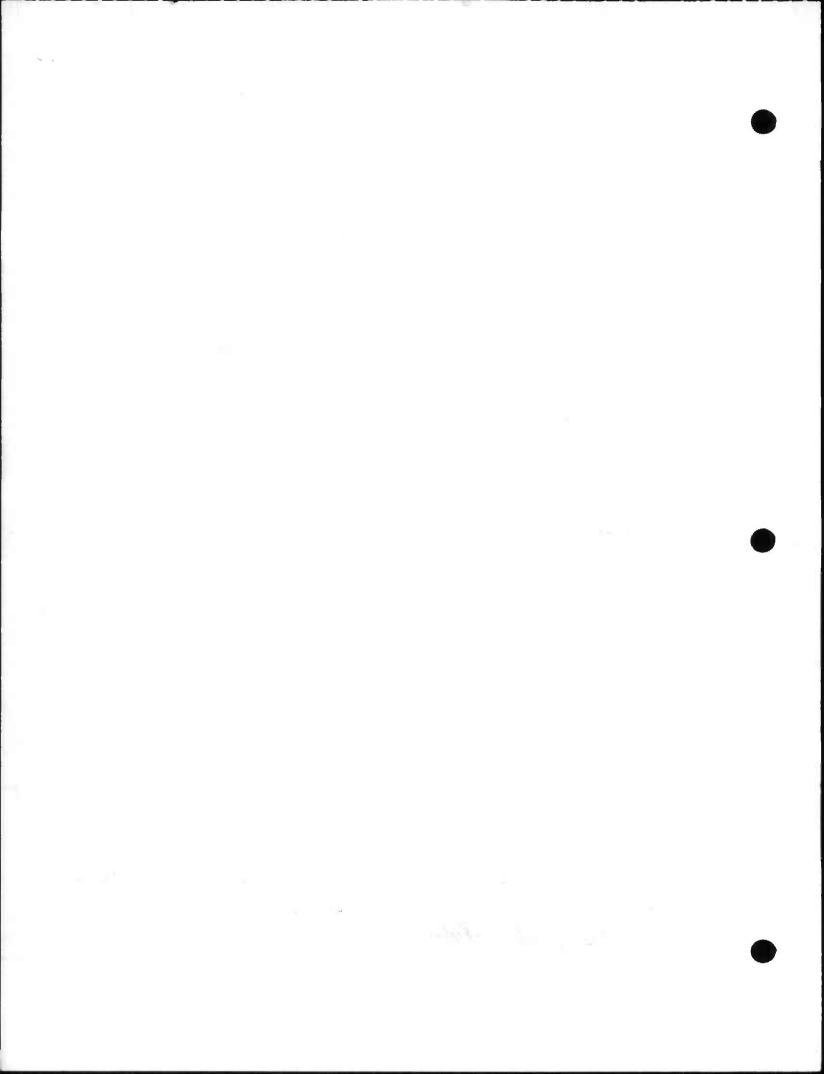
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Lest) Eleanor Carmella	a Hicks				2. DATE OF DEATH December	7, 1994	a. TIME OF DEATH 12:35A M				
	051-07-1754	□ M 2 🖰 F 92		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	a.	BIRTHPLACE (State or Foreign Country) Italy				
TOR	9a. FACILITY NAME (If not institution, give street Overlea Gardens No RESIDENCE OF DECEDENT			Baltimo	or Location of Di	EATH	9c. COUNTY	9c. COUNTY OF DEATH				
DIRECTOR	10a. STATE 10b. COUNTY			imore	ION		10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
FUNERAL	100. STREET AND NUMBER 4210 Bayonne Avenu	ie	Dare		21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A					
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	₩ NO	If yes, sp	ENDENT OF HISPAI ecify Cuban, Mexica XIX NO Specifi	s or No- 14. RACE — American Indian, Black, White, atc. Specify: White						
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade composition) Elementary/Secondary (0-12) 8 Years	ON 164 photed) 164 ollege (1-4 or 5 +)	CGive kind of work its. Do NOT use ref	done during mo. ired.)	IN st of working	JSINESS/INOUS						
COM	17. FATHER'S NAME (First, Middle, Last)		nousewii	Е	18. MOTHER'S NA	Hom ME (First, Middle, Maide)						
BE (Vincenzio Ales		-		Rosa							
2	19a, INFORMANT'S NAME (TyperPrint) Emma Smith 19b. MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, State, Zio Code) 4226 Bayonne Avenue Balto. Md 21206											
	20stMETHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify)	from State cemeter	y, cremetory or other p	viece)		12/10/94	Raltin	y or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE LICENS Martin J. D.	- 1	lens of F	7110 B	elair Ro	pad Balto.	ppel Fu	neral Home Inc				
	23. PART I. Enter the diseases, pr companded, or heart failure. Liet	plications that caused the	e death. Do not e	enter the mo	de of dying, auc	h as cerdiac or reap	oiratory arrest					
	IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Due to (or as a consequence of):											
TION	Sequentially list conditions, If any, leading to immediate											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in deeth) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):									
AL	PART II. Other aignificant conditions co		not resulting in th	e underlying	cause given in	Part I. 24a. WAS AI PERFQ		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
PHYSICIAN: MEDIC	Demen					1 YES	2 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
IAN	DID TOBACCO USE CONTRIBUTION OF THE PROPERTY O		PLACE OF DEATH (C		UNCERTAI	N 🔲		L				
YSIC	1 Tes 2 No	OSPITAL: Inpatient 2 ER/Outpetier	nt 3 DOA 4	HER: Nursing Home	5 - Residence	8 Other (Specify)						
	27. MANNER OF DEATH Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WO		28d. OEŞCRIBE HOW	INJURY OCCUR	RED				
TED BY	2 Accident Investigation 3 Suicide a Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — A building, atc. (Specify)	At home, ferm, atreet			2af. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED		: To the best of my knowledge in the bests of examination and						ause(e) and manner ea stated.				
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	000	0		29c. LICENSE NUI			IGNEO (Month, Day, Year)				
5	30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print)	1214	175	P 2	12-4-94				
	DECU 9 1994 Julia	32. REGISTRARY SIGNATUR	RE									

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DIVISION OF VITAL RECORDS, P.O.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H			GIENE						
	1. DECEDENT'S NAME (First, Middle, Last)	ES				2. DATE OF D		YEAR 9 N	3. TIME OF OEATH				
			yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH .	, , ,	LACE (State or Foreign				
	204-09-4482 1 9e. FACILITY NAME (If not institution, give stree	□ M 2 X) F 8 2	YAS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 7-25-1912 Pa			•				
DIRECTOR	Johns Hopkins		Ctr.		more C		9c. COU	INTY OF DE	ATH				
EC	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION			T.	10d, INSIDE CITY				
DIR		imore		Dunda1	k				LIMITS?				
FUNERAL	100. STREET AND NUMBER 2000 Wareham Ro	4		101	. ZIP CODE		10g. CIT		HAT COUNTRY?				
JNE		2. WAS OECEDENT EVER IN U	S ADMED	12 WAS DEC	21222 ENDENT OF HISPA			USA					
BY FL	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 XNO	If yes, sp	ecify Cuban, Maxico	an, Puarto Rican,	etc.)		- American Indien, White, etc. : White				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION 1	6a. DECEDENT'S I (Give kind of w life. Do NOT use	ork done during ma		16b. KIND	OF BUSINESS/IN	DUSTRY					
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Waitr			Re	staurar	n t					
O	17. FATHER'S NAME (First, Middle, Last)		Waldi	CDD	18. MOTHER'S NA		Maiden Surname)	10					
BE C	John Argust				Marga	aret E	. Fugil	11					
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street o	nd Number or Rural	Route Number, Cit	y or Town, State, Zij	p Code)					
۴	Virginia Smith		2000	Wareh	am Rd.	Balt	imore,	Md.	21222				
	20a. METHOD OF DISPOSITION 1												
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME A	ID ADDRESS OF FA								
Connelly Funeral Home of Dur 7110 Sollers Pt Rd 21222													
	23. PART I. Enter the diseases, or com shock, or heart failure. Lis	plications that caused y t only one cause on eac	h∳death. Do n hJline.	ot enter the mo	de of dying, suc	ch as cardiec o	r respiratory an	rest,	Approximate interval Batween				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) e. CP												
	resulting in death) OUE TO (OR AS A CONSEQUENCE OF):												
NO	Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF):												
₩.	if eny, leading to immediate cause. Enter UNDERLYING												
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	*									
	DART II Other classificant and distance								+				
DICAL	PART II. Other significent conditions of	ontributing to deeth but	not resulting in	the underlying	j ceuse given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	6	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDIC									YES 2 NO				
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO-MEDICAL				UNCERTAI	N 🗆 📗							
Sic	EXAMINER?	OSPITAL:		OTHEB									
HYS	27. MANNER OF DEATH	Inpatient 2 ER/Outpati	28b. TIME		5 Residence		HOW INJURY OC	CHRED					
	1 Netural 5 Pending	(Month, Day, Year)	INJU	RY WO	RK? ES 2 NO		THOM INCOME OF	CONED					
ETED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm, st	reet, factory, office		261. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
	29e. CERTIFIER			<u> </u>									
COMPL	(Check only 1 CERTIFYING PHYSICIAL One) 2 MEDICAL EXAMINER: C	N: To the best of my knowled on the basis of axamination a							and manner as stated.				
BE C	29b. SIGNATURE AND TITLE OF CERTIFICAL	Ac			29c. LICENSE NUI	WBER	29d. DAT		Month, Day, Year)				
TO B		IT WW			137	58C	▶ 6.	8 5	94				
F	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	(ITEM 27) (Type,	Print) BAY	VIEW	CICO	10 8	N	-all				
	DEC 9 1994 Juli	Julius Carl	(LE										





DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withly. About after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Lest)	1/	rajay	Łi.		2. DATE OF DEATH DATE OF	04 954	3. TIME OF DEATH 2150 M			
	4. SOCIAL SECURITY NUMBER 213-01-3022	1 M 2 D F	79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	HPLACE (State or Foreign					
TOR	9a. FACILITY NAME (If not institution, give CHURCH HOSPITA) RESIDENCE OF DECEDENT			96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE MARYLAND 9c. COUNTY OF DEATH							
DIRECTOR	10a. STATE MARYLAND 10b. COUNT	ΓY		Y, TOWN OR LOCALTIMO			10d. INSIDE CITY LIMITS? 14 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 6722 RAILWAY	AVENUE			or. ZIP CODE 21222		10g. CITIZEN OF	WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 2 NO	If yea,	CENDENT OF HISPAI specify Cuban, Maxica S 2 X NO Specif	NIC ORIGIN? (Specify Yea in, Puerto Ricen, etc.) y:					
COMPLETED	15. DECEOENT'S EDI (Specify only highest grad	UCATION le completed) College (1-4 or 5+)	18e. DECEDENT'S (Give kind of the Do NOT us.) MILK M	work done during i se retired.)	TION nost of working	Section (Section	SPRING	3			
BE CON	17. FATHER'S NAME (First, Middle, Last) JOSEPH KARWA(CKI			HELEN	ME (First, Middle, Maiden					
5	190. INFORMANT'S NAME (Type/Print) MRS. MARY D. KA	ARWACKI				Route Number, City or Town		1222			
	20a, METHOD OF/DISPOSITION 1 Burlel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State	REEN OF MC	UNT CH	EMETERY	12-7 BA	LTO., M				
	Karles K. X	desur	di	1201	. DUNDAL	FUNERAL K AVENUE	BALTO.	MD. 21222			
NOI	23. PART I. Enter tha diseasee, of complications that caused the daeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finei disease or condition resulting in deeth) a. Out TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a Atten	CONSEQUENCE OF	10 C	an diove	acular	Obles	0			
A	PART II. Other algnificent condition	150			· .	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	CONTRIBUTE TO	CAUSE O	28.	YES NO						
PHYSI	1 VES 2 TOO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. II	iJURY AT	8 Other (Specify) 26d. DE\$CRIBE HOW II	NJURY OCCURED				
ED BY	2 Accident Investigation 3 Suicide e Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm,		YES 2 NO	281. LOCATION (Street & City or Town, State)	and Number or Rural	Route Number,			
COMPLET	000)	SICIAN: To the best of my knowl						(a) and manner as stated.			
O BE CO	290. SIGNAPURE AND TITLE OF CERTIFIE	ER (MAC)			29c, LICENSE NUI						
		ADINA	101 B	Print) ROAD (PAN	BALTIM	IORE				
	31. DATE FILEO (Month, Dey, Year) DFC 0 9 1994	32. REGISTRAR'S SIGN.						DHMH-18 Rev 1/89			

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float hand the float of may be retained by the hospital or attending physician.

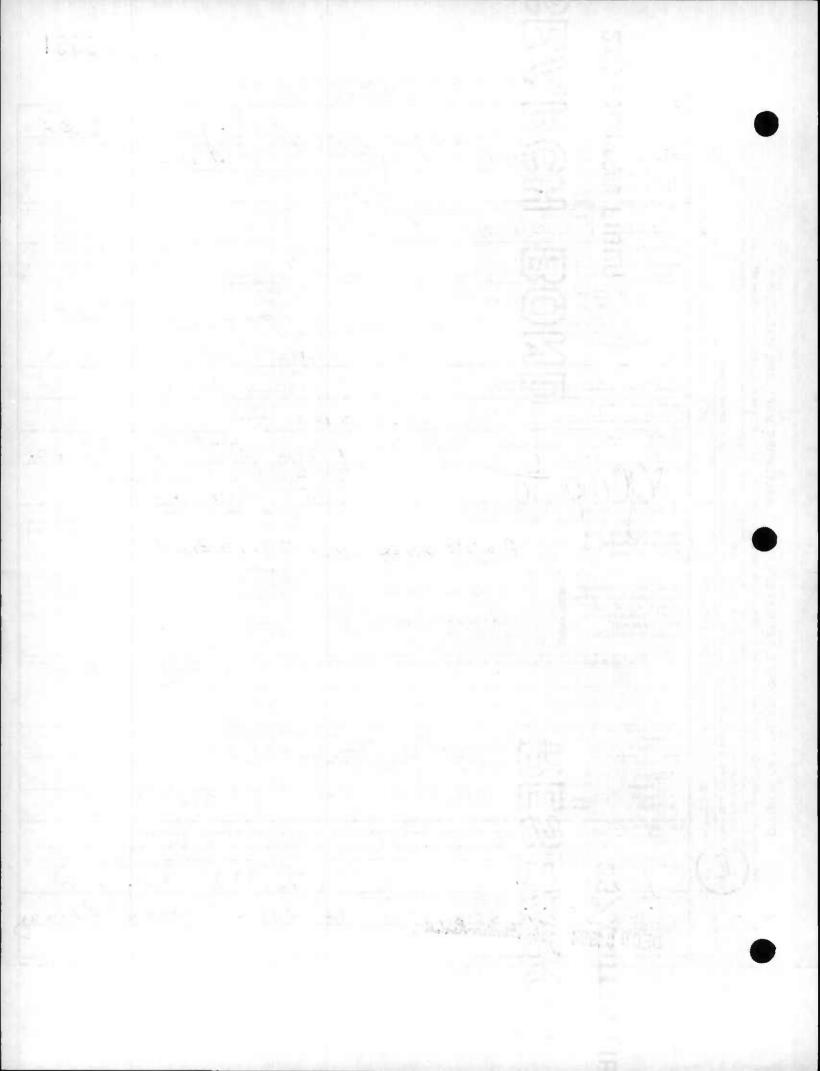
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INTERPRETABLE HERE 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	HEGISTRAH				DILL	TOATI	CUL	DEA	I II		REG. NO.			
	1. DECEDENT'S NAME (First, M BEN			6, 1	994	YEAR	3. TIME OF DEATH 8:30 A M							
	4. SOCIAL SECURITY NUMBER 579 12 639		5. SEX 12 M 2 [] F	6. AGE (In yrs. les 83	t birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE NOV	of BIRTH	911	8. BIRTI	PLACE (State or Foreign
OR	90. FACILITY NAME (If not insti 6120 Durbi	n Rd				96. am Bet		da	ON OF DE	eath 96. COUNTY OF DEATH Montgomery				
DIRECTOR	Maryland	lob. COUNT	tgomery	,		ry, rown o							10d. INSIDE CITY LIMITS? 1 YES X NO	
FUNERAL	100. STREET AND NUMBER 6120 Durbi		101. ZIP CODE 20817					1177				WHAT COUNTRY? States		
B	11. MARITAL STATUS 1 Never Married 2 M M 3 Widowed 4 Divorce	NT EVER IN U.S. AR	2 NO If yes, specify Cuban, Mexica							E — American Indian, k, White, etc.				
COMPLETED	15. DECED (Specify only h	DENT'S EDU		16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON ost of workli	na	16	b. KIND OF BUS	INESS/IN	DUSTRY	
PLE	Elementary/Secondary (0-1)	+)	Do NOT u	se retired.)		sign			Priva	te F	Busi	ness		
500	17. FATHER'S NAME (First, Mide Kalman Kir		nhaum					18. MOT	HER'S NA	ME (First,	Middle, Meiden	Sumame)		
100	19e. INFORMANT'S NAME (Typ			191	b. MAILING	ADDRES	\$ (Street o				nber, City or Yowi		io Codel	
2	Bertha Kir			S	ame	add	res	s as	5 #1	0				
	20a. METHOD OF DISPOSITION YO Buriel 2 Cremation 3 Removal from State 4 Denotion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of emplayer, cremation, cremation										Fall	City or To	hurch, Va.	
-	21. SIGNATURE OF PUNESAL	CEMPE	22.	IV	es-I	ear	SOn	Fune:	ral	Hom	es			
CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of):													
100	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? AMA											WERE AUTOPSY FINDINGS		
E MEDICAL											1 TYES 2	₹ X no		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
THI SICIAIN.	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOODITAL					LACE OF D	EATH (Ch	eck only o	ne)			
5	1 TYES 2 NO			☐ ER/Outpetient 3	□ DOA	4 Nu		10 5 R	esidence	6 🗆 Oth	er (Specify)			
	27. MANNER OF DEATH NEW Netural 5 Per lim	ending vestigation	26e. DATE OF		28b. Tili	AE OF JURY M		ORK? YES 2] NO	28d. DE	SCRIBE HOW II	NJURY OC	CURED	
	2 Accident Im 3 Suicide 6 Co 4 Homicide de	OF INJURY — At he etc. (Specify)	- At home, ferm, street, factory, office				261. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
			ICIAN: To the best of											e) end menner ee stated.
1	296. SIGNATURE AND TITLE O										,			
9	15%		DO 199			29d. DATE SIGNED (Month, Day, Year) Dec. 6,1994								
	1040 CD	n, M	AD.	SE OF DEATH (ITE	M 27) (Type	e, Print)	41) 5	208	39.	5-K		_	S KIRWW
31. DATE FILED (Month) Day (Mar)											-			



-9000)	n vertament permit. Pages 1, 2, 3)
BALTIMORE, MARYLAND 21215-0026	4 hours after death. Page 6 may be retained by the hospital or atte	illed in by the funeral director, page 5 should be detached for use in or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within z	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use an experiment or many Mental Hydiene prior to burial, cremation, or removal.	PORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I

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943 94-7070-510 Item 1, g-718, 12-9-94, per f.h., dr 94 36552 asp FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994 EAR DEC 05 11:53 P M KELLY N. LEMMON-Kelly Nicole Lemmon 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7 DATE OF BIRTH 6. BIRTHPLACE (State or Foreign OCT. 23, DAYS HOURS 215-92-4013 1 | M 2 | F 16 1978 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MARYLAND SHOCK TRAUMA BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND n/a BALTIMORE X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 110 CHERRY HILL ROAD 21225 UNITED STATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf was specify Cuban, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 1 XNever Married 2 Married 1 YES 2X XNO Specify: Specify BLACK BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5 +) COMPL 11 TH STUDENT n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) THOMAS LEMMON notified at DEBORAH WINSTON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 **DE BORAH** HORNE CHERRY HILL ROAD, BALTIMORE, MD 21225 pe 20a. METHOD OF DISPOSITION

↑ ☑ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must Burlal BAL TIMORE CEMETERY 5 Other (Specify) 1a - 10BALTIMORE. MD examiner FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate shock, Dr heert failure. Liet pnly pne ause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death the disesse or condition resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEDUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART ii. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL tem HOSPITAL:
1 | Xinpatient 2 | ER/Outpatient 3 | DOA OTHER: 1X YES 2 □ NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 OATE OF INJUR 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? AND DESCRIBE HOW INJURY OCCUPED INJURY M 1 Natural 15 1 YES Accident Sen BY Investigation 28a. PLACE OF INJURY — At home, term, street, tactory, office building, atc. (Specify) 281 LOCATION /S 60 COMPLETED 6 Could not be

3000 4 Homicide 29a. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: 96 of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as atted. 96. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Your)
DEC 06, 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CO

111 Penn Street, Baltimore, Maryland 21201

29c. LICENSE NUMBER

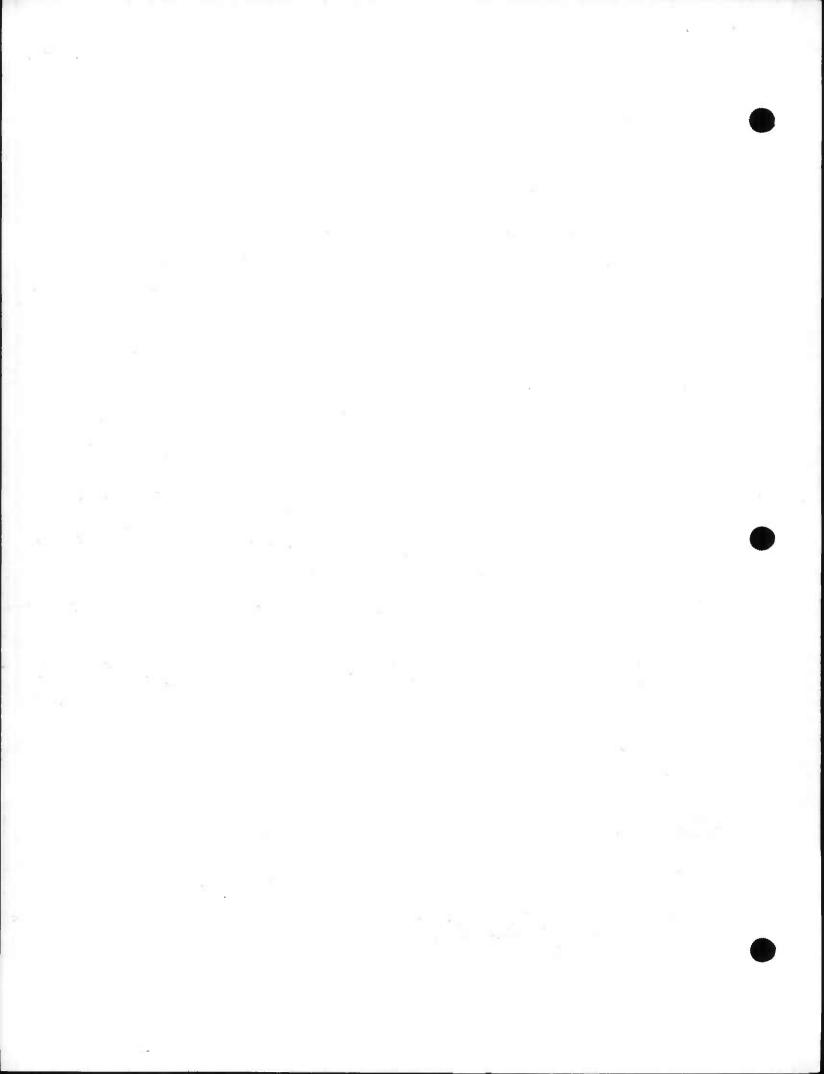
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32. REMISTRARY SIGNATURE 9 1994

		1. DECEDENT'S NAME (First,	Middle Leat								A DATE OF S			
			,	les Long	.Jr.						- 0		YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.	last history	IE IMPO		ME 1 man	0.000	Dec. 3		994	1550 M
							MONTHS	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPI Country)	LACE (State or Foreign
P	1 1	215-32-2507		1 M 2 F	65	YHS.					June 1, 1		Mary.	
should	~	9a. FACILITY NAME (If not in					The state of the s						TY OF DEA	АТН
2. 3	стов	Carroll Cou	inty G	eneral Ho	ospital		We:	stmi	inste:	r		Carroll		
SS.	т ш	10a. STATE	10b. COUNTY	1		10c. CITY, TOWN OR LOCATION							T.	IOd. INSIDE CITY
Pag	DIR	Maryland	Fro	derick		New Windsor								LIMITS?
permit		10e. STREET AND NUMBER	FIE	TELICK		IN	EW W.		of. ZIP COD	-		T		YES 2 NO
	ERAL	15005 A To	11 Ros	d	Υ.			1 "	or. ZIP COD	217	176			IAT COUNTRY?
020 physician. burial-transit	Z	11. MARITAL STATUS	II NOA	12. WAS DECEDER	T FIFT IN II O	4 mass	Loc						tates	
020 physician burial-tra	FUN	1 Never Married 2	Married	FORCES?	YES 23	NO	- 1	If yes, s	pecify Cuba	in, Mexica	NIC ORIGIN? (Specify Yar in, Puarto Rican, etc.)	or No-	Black,	- American Indian, White, atc.
	B	3 Widowed 4 Divo	rced	IF YES, GIVE V	MAR OR DATES			1 TYES	S 2 🙀 NO	Specify	y:	- 1	Specify:	White
Z15-0 attending se as the	유	15. DEC	EDENT'S EDU	CATION	18a.	DECEDENT'S	S USUAL O	CCUPATI	ION		16b. KIND OF BU	SINESS/INDI		
		(Specify only Elementary/Secondary (0	y highest grade	completed) College (1-4 or 5		(Give kind of life, Do NOT a	work done	during m	nost of working	ng		3111200711100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
the hospital or detached for u	COMPL	7th grade	-12)	College (1-4 or 5	*)	Carpe	nter	nter Volpe Constructi					ion Company	
AND he hospil detached once.	NO.	17. FATHER'S NAME (First, M	iddle, Last)			oarpe	18. MOTHER'S NAME (Firs						Luce	Ton Company
\$ & &	Ш	Benjamin C.	Long.	Sr.				Bessie Fritz						
retained 5 should notified		19a. INFORMANT'S NAME (7				19b MAILIN	G ADDRES	S (Street			Route Number, City or Tow	on Chata 7in i	Code)	
retail 5 sh	임	Mrs. Edith	L. Lon	Q							w Windsor,		2177	6
may be		20a. METHOD OF DISPOSIT		0	20h Pl AC					110				
D w E		20b. PLACE AND DATE OF DISPOSITION 1 X Burlal 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Bethany Cemetery 12/6 New Windsor, Maryland												
E 6 6 E		21. SIGNATURE OF FUNERA		CENSEE	Deti	lally (AND ADDRE	SS OF FA		V Wind	isor,	Maryland
death. P tuneral				a C							Funeral Di	recto	rs.	РΔ
2 2 2 8		Jam	or ?	o Cat	recy		12	12 V	w. 01	d Li	berty Road	1 Winf	ield	, MD 21784
urs after in by the removal		23. PART / Enter the di	seasea, or o	complications the	t quaed the	deeth. Do	not enter	the mo	ode of dy	ing, auc	h ea cerdiec or reep	ratory arre	et,	Approximate
100	1	IMMEDIATE CAUSE (Fir		cist only one car	ase on eech a	- A-			1				7	Interval Between Onset and Death
4 th 4		disease or condition resulting in death)	→		4cu	To	C	a /	ad	14	c. an	nea	X	Low
went		reading in dealing		DUE TO	IOR AS A CONS	SEQUENCE ()F):	4		,				1
oching of the selection	z		-	a	rte	rio	se	U	cro	li	e car	di	0 -	
A de	CATION	Sequentially list conditi if any, leading to imme		DUE 10	(OR AS A CONS	SEQUENCE O	OF):	0)	11	i			1 1000
S a see E	2	CAUSE (Disease or Inju		ε.	4	va	20	N	-	_ 0	usia	all	-	years
of the state of the control of the state of the control of the con	CERTIFI	that initiated events		DUE TO	OR AS A CONS	REQUENCE O	OF):							V
1 6 8 5 B	EH	resulting in death) LAS		đ										
Ment of Ges		PART II. Other significa	nt condition	s contributing to	death but no	d regulation	fin theres	dochio		oliven in	Best I Tree was an	ALCOHOLD .	Lacar	
A SESTINA	CAL	T To	6 . t	-	PI	1		oenyin S	ig cause (given in	Part I. 24s. WAS AN PERFOR		- 1	WAILABLE PRIOR TO
S and a	ă	- ara	A	-m			_	_		_	1 □ YES 2	LINO		OMPLETION OF CAUSE OF DEATH?
security of Hu	×	- geo	ref										- 12	O YES 2 DAG
Zan bu	ä								la la constitución de la constit					1.51
一 年 在 4 日	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	D-MEDICAL	HOSPITAL		_	ОТНЕ		LACE OF D	EATH (CH	eck unity one)			
or III	> II	1 TYES 2 DAG		1 Inpatient 2		3 DOA			me S I fle	reldence	⊕ Other (Specify)			
PHYSICIAN: this certifica with the Sa riced, or It	H	27. MANNEY OF DEATH	No. of Contract of	28s. DATE Of (Month, 2		286. TO	WE OF JURY		UURY AT		28d, DESCRIBE HOW I	NJURY OCCU	JRED	
	84		Pending Investigation		AND THE REAL PROPERTY.		м		YES 2] NO				
J E 4 6 _	ED	3 Suicide 6 S	Could not be determined	28s. PLACE C building.	of INJURY At etc. (Specify)	home, farm.	street, fact	ory, offic	ce		281. LOCATION (Street of City or Town, State)		ir Pluret Ploy	its Numbec
OR ATTEND DIRECTOR: Noun after Man 28 is														
T OB Y	7		IFYING PHYSI	CIAN: To the best of	my knowledge,	death occur	red at the !	ime, date	e and place	and due	to the coune(s) and mar	oner en state	d.	
HOSPITAL WITH 72 TANTE II	COM	new) 2 MEDI	CAL EXAMINE	R: On the basis of a	examination and/	or investigati	on, in my t	pinion, i	death occur	red at the	time, date and place, en	d due to the	cause(x) s	and manner as stated.
TO THE HOSPIT TO THE PUNERS De filed within 7 IMPORTANT:	EC	29h. SIGNATURE AND TITLE	OF CERTIFIES	1					29c. LICE	ENSE NUN	NUER	29d. DATE	SIGNED /S	Asseth, Dwy. Hear)
E SE	m	DKre	سما	43	an	10	april .		D	14	992	10		3,994
F F D =	5	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH	TEM 27) (%)	Prints	0.2000	130	V	90	,		7 1
		EDHRA	IM	BAR	7 A	GF	7	NI	EIR	1.	WINd	200	> /	21 d. 2177
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		DEC 0 9 19	94 4	ly d'avele	AR'S SIGNATURE								5	
	النبسيا		- ()											

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

FOR STATE REGISTRAR



BALTIMORE, MARYLAND 21215-0020

VIVISION OF VITAL RECORDS, P.O. BOX 68760

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THE NTENDING PHYSICIAN: The law requires that the death certificate be executed withing whoms after death. Page 6 may be retained by the buspital or attending physician.

OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should have after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT, If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARY REGISTRAR		NT OF HEALTH AND N	MENTAL HYGIENE REG. NO.							
	1. OECEOENT'S NAME (First, Middle, Linst)	_		2. DATE OF DEATN	3. TIME OF DEATN						
	LESTER CHARLES Mc CR	EA		DEC. 7, 1994	5:30 P.M M						
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGI	7. DATE OF BIRTN (Month, Day, Year)	6. BIRTNPLACE (State or Foreign Country)								
	214 40 7933 1 MM 2 F 52 YRS. MONTHS DAYS HOURS MIN. MAR. 17, 1942 MAY 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DE										
OB	5123 QUEENSBERY AVENUE	36.	BALTIMORE		MIT OF DEATN						
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c, CITY, TOW	10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY								
DIR	MARYLAND		LTIMORE		LIMITS?						
	10e. STREET AND NUMBER		10f. ZIP CODE	10g. CIT	TIZEN OF WHAT COUNTRY?						
FUNERAL	3711 WOODBINE AVENUE		21207	U.:	S. OF A.						
5	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YE	IN U.S. ARMED	13. WAS DECENDENT OF NISPAN If yes, specify Cuban, Maxican		14. RACE — American Indian, Black, White, etc.						
BY	1 Never Merried 2 Merried FORCES? 1 YE IF YES, GIVE WAR OR	DATES	1 YES 2 NO Specify.		Specify: BLACK						
	15. DECEMENT'S EDUCATION	16a. DECEDENT'S USUA	LOCCUPATION	18b. KIND OF BUSINESS/IN	1						
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of work de life. Do NOT use retire	one during most of working	Too. KIND OF BOSINESS/IN	DOSINI						
AP.	12th 12 YEARS	SCHOOL AL	MINISTRATOR	PUBLIC SC	HOOLS						
Ö	17. FATNER'S NAME (First, Middle, Last)		16. MOTNER'S NAM	AE (First, Middle, Maiden Surname)							
BE	LESTER MITCHELL Mc CR			HASKINS							
6	19a. INFORMANT'S NAME (Type/Print)		IESS (Street and Number or Rural R								
	MRS. ROWENA Mc CREA	3711 WC	OODBINE AVE.		, MD. 21207						
	1 Buriel 2 Cremation 3 Removal from State	metery cremetory or other plant RBUTUS MEN			ORE, MARYLAND						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEEL EWIS T	CUVNN	22. NAME AND ADDRESS OF FAC	ILITY							
	Lewis I Surehus	, μ		NN FUNERAL	HOME 21215 BALTIMORE,MD.						
	23. PART I. Enter the diseases, Dr complications that caus	d tha death. Do not en	iter the mode of dying, such	as cardiac or raspiratory ar	rreat, Approximate						
	ahock, or heart failure. List only one cause on IMMEDIATE CAUSE (Final		Interval Between Onset and Death								
ļ	immediate cause (Final disease or condition resulting in dasth) a. Pancreatic Cancer Oue to (or as a consequence of):										
_	OUE TO (OR AS	A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, If any, laading to immediata b. OUE TO (OR AS A CONSEQUENCE OF):										
CA	cause. Enter UNDERLYING CAUSE (Disease or injury										
F	that initiated events resulting in death) LAST	A CONSEQUENCE OF):									
GE	d										
ÄL	PART II. Other algnificant conditions contributing to death	but not resulting in the	underlying causa given in I	Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO						
ö				1 YES 2 NO	COMPLETION OF CAUSE OF DEATH?						
PHYSICIAN: MEDIC	DID TORACCO LIST CONTRIBUTE TO CAUSE	DE DEATH WES	1 110	_	1 TYES 2 NO						
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE (25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (Chi									
Sic	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Ou	OTH	IER:	3 ☐ Other (Specify)							
Ŧ	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	26c. INJURY AT	28d. DESCRIBE NOW INJURY OC	CCURED						
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	INJURY	WORK? 1 YES 2 NO								
	3 Suicide 6 Could not be detarmined 4 Homicide detarmined	261. LOCATION (Street and Number City or Town, State)	or or Rural Route Number,								
	20a CERTIFIER										
COMPLETED	(Check only one) CERTIFYING PHYSICIAN: To the best of my known one) MEDICAL EXAMINER: On the basis of axaminst										
	29b. SIONATURE AND TITLE OF CERTIFIER		29c. LICENSE NUM		TE SIGNEO (Morth, Day, Year)						
TO BE	STAMUS O'REILLY		D465	15	12994						
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Print)	ONCOLOG	Cata							
	31. DATE FILEO (Month, Day, Year)	MATERIAL MORA	UNCOZULA!	7 conjer							
	DEC 0 9 1994 July When to	rdalle		J							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.	ate has been signed by the attending physician and completely	filed writhin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.
TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this cer	be filed within 72 hours after death with the S	IMPORTANT: It item 28 is marked, o

Contact Security Museum Contact No. Market, 1000 Contact No.	REGISTRAR				CERTIFI	CALE	OF DEA	TH	1	REG. NO.			
SECURITY NUMBERS SEX			Weslev		Mayor	•			2. DATE OF	OEATH DAY.	100%	YEAR 3.	
21.5-18-9595 INDICATE STATE OF A STATE AND A STATE AN						_							
Security makes from constitutions, pris above and monotory Security makes from constitution Security makes from con			S. SEX 6. AGE (In yrs. last birthday) 1 L M 2 F 71 YRS. 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF I (Month, pr. MAY) MAY MAY T MAY T MAY T MAY						BIRTH 1923	•	Country) Balt	O. Md.	
MATYLAND General Hospital Baltimore Residence of proficialist No. STREET MON COUNTY M. Baltimore No. STREET MON COMPANY M. Baltimore No. STREET MON COMPANY NO. STREET	9a. FACILITY NAME (# n	ot institution, give	street and number)			9b. CITY, TO	WN OR LOCAT	ION OF DE			9c. COUNT	Y OF DEAT	н
Separate			ral Hospi	tal]	Baltim	ore					
Md. Baltimore Reisterstown Reisterstown St. Decode 100 per 100													
Sequentially list conditions					10c. CITY,			town					LIMITSZ
### SACT I Vydale Ave. ### 15 West Decorpor EVEN HI U.S. ARRED ### West Ave. ### 15 West Decorpor EVEN HI U.S. ARRED ### VIE. OVER DECORPOR EVEN HIS ARRED ### VIE. OVER DECORPOR EVEN HIS ARRED ### VIE. OVER BOAT HIS AR	10e. STREET AND NUME	ER					101. ZIP CO	Œ			10a. CITIZE	N OF WHA	T COUNTRY?
Toke Warried Sign Married FORCES Sign YES 2 Sign The Security The S		ydale A	ve.					2113	36				
St. DECEMBENTS EDUCATION St. DECEMBENTS EDUCATION St. DECEMBENTS SURVEY COUNTY St. NOTICE of the strain St. DECEMBENTS SURVEY COUNTY St. NOTICE St.	1 Never Married 2-	_	FORCES? 1	YES 2	NO	If yes	s, specify Cub	an, Mexical	n, Puerto Rica	Specify Yea o an, atc.)	r No- 14	Specify:	hite, atc.
Charles (and continued price) Charles E. Mayer The information for description of the control				18a	. DECEOENT'S L	JSUAL OCCU	PATION	_	16b. KI	ND OF BUSIN	IESS/INDU		
11. MOTHER'S NAME (Pierl, Models, Last) Charles E. Meyer Ital MOTHER'S NAME (Pierl, Models, Last) Delma Wright Ital MARLING ADDRESS (Street and Mumber or Abust Pouls Mumber, City or Bown, Street, 20 Code) Mrs. Helena M. Meyer 320. MENDO or Deposition Mrs. Helena M. Meyer 321. Toylada Ave. Reisterstown, Md. 21136 322. PART I Enter the diseases, or compilections that caused the death. Do not enter the mode of dying, such as certified or respiratory arread. Italian Funeral Home 122. PART I Enter the diseases, or compilections that caused the death. Do not enter the mode of dying, such as certified or respiratory arread. Interval Between Overland Street (Market House) I arry, leading to immediate the death of the such as a constitution of the substitution of the subs	Elementary/Seconder	y (0-12)			(Give kind of we life. Do NOT use	ork done durin retired.)	g most of work	ing					
The interest events of the conditions of the con			-		ме	cnanı							
MTS. Helena M. Meyer 827 TVydale Ave. Reisterstown, Md. 21136 306 PLACE AND DATE OF DEPOSITION DATE D			Meyer				18. MO1				mame)		
MTS. Helena M. Meyer 827 TVydale Ave. Reisterstown, Md. 21136 306 PLACE AND DATE OF DEPOSITION DATE D	19a, INFORMANT'S NAM				19b, MAILING	ADDRESS (Sh	eet and Numbe	or Rural F	Route Number	City or Town	State. Zin C	odel	
Constinct South (Speech) Garrison Forest Vet.Cemetery Owings Mills, Md. 21			eyer										36
Eline Funeral Home Reisterstown Roa. Reisterstown Md. 2113 23. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List pnly one ceuse on sech line. MAMEDIATE CAUSE (Final diseases, or complications) Approximate interval Between the resulting in death) Toxie Metabolic Encephalopathy DUE TO (or AS A CONSEQUENCE OF): Cronic Renal Failure DUE TO (or AS A CONSEQUENCE OF): CLOSE (Disease or injury that initiated events resulting in death) DUE TO (or AS A CONSEQUENCE OF): CLOSE (Disease or injury that initiated events resulting in the underlying ceuse given in Part I. 24s. Was AN AUTOPSY PROPORT TO GOARTH TENDER OF CAUSE (Disease) DUE TO (or AS A CONSEQUENCE OF): DUE TO (or AS A CONSEQUENCE OF): DUE TO (or AS A CONSEQUENCE OF): 25. WAS CASE REFERRED TO MEDICAL EXAMINATED. 1	20a, METHOD OF DISPO 1 N Buriel 2 Crem 4 Donation 5 0	SITION ation 3 - Ren ther (Specify)	noval from State	20b. PLA	ACEAND DATE OF	FDISPOSITIO	N(Name of t Vet.	Ceme	DATE				
22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, approximate interval Between Charles (Pinal Indian). Approximate interval Between Charles (Pinal Indian). Toxie Metabolic Encephalopathy umknown conset and Death Umknown conset and Death Umknown Charles (Pinal Indian). Sequentially list conditions, if any, isoding to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that in a cause, Enter UNDERLYING CAUSE (Disease or injury that in a cause). PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART II. Other eignificent conditions. PART II. Other	21. SIGNATURE OF FUNI	ERAL SERVICE LI	CENSEE										
Cronic Renal Failure Due to (or as a consequence of): Cronic Renal Failure Due to (or as a consequence of): Due to (or as a consequence of	MMEDIATE CAUSE disease or condition	r haert fallure. (Final	Toxi.	e Me	_{llne.} taboli	.c En				c or reepira	tory arres	ıt,	Interval Between Onset and Death
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28. PLACE OF INJURY At North No	If any, leeding to im- cause. Enter UNDER CAUSE (Disease or i that initiated events	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANHER OF DEATH 1 Stephalent 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28. DATE OF INJURY AT NORKY 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 3 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) Shelonitda Rose, M.D. c/o Maryland Gneral Hospital 31. DATE FILED (Month, Day, Year)	PART ii. Other eigni	licent condition	na contributing to	death but n	ot reaulting in	the under	lying ceuse	given in	Part I. 24	la, WAS AN AL	TOPSY	24b. WE	RE AUTOPSY FINDINGS
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH Check only one) 27. MANNER OF DEATH							- 121					CO	AILABLE PRIOR TO IMPLETION OF CAUSE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1											7		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one)	DID TOBACO	CO USE (CONTRIBUTE	TO CA	USE OF	DEATH	YES	NO					
EXAMINER? 1 VES 2 VO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 DOA 2 DOA 2 DOA 2 DOA 2 DOA 2 DOA 3 DOA 3 DOA 4 DOA 5 DOA	25. WAS CASE REFERRE							DEATH (Ch	eck only one)				
27. MANNER OF DEATH Netural				FR/Outpation		OTHER:	12-						
1 Netural 2 Accident 3 Suicide 4 Homicide 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO-COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. DATE FILED (Month, Day, Year) 33. DATE FILED (Month, Day, Year) 34. DATE FILED (Month, Day, Year) 35. DATE FILED (Month, Day, Year) 36. DATE FILED (Month, Day, Year) 37.			Ι					esidence			IIBA OCCII	DED.	
28e. PLACE OF INJURY — At home, farm, street, factory, office 4 Homicide 29e. CERTIFFIER (Check only or it) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Shelonitda Rose, M.D. c/o Maryland Gneral Hospital 31. DATE FILED (Month, Day, Year)	1 Natural 5					IRY	WORK?	□ NO	zeu. Deșch	IBE NOW ING	ONT OCCO	RED	
(Check only 10 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Shelonitda Rose, M.D. c/o Maryland Gneral Hospital 31. DATE FILED (Month, Day, Year)	3 Suicide 8	Could not be	28e. PLACE OF building, a	INJURY — A	At home, farm, at	reet, factory,	office				f Number or	Rural Route	» Number,
# Spello Sam HOUSE SIAKE 89225	(Check only												d manner as stated.
Shelonitda Rose, M.D. c/o Maryland Gneral Hospital 31. Date FILED (Month, Day, Year)	J.	Shelos	am		Hous	E SIAI			ABER	2			
31. DATE FILED (Month, Dey, Yeer)							nd Gn	era1	L Hos	pital			
	31. DATE FILED (Month, E	Pay, Year)	32 REGISTING					2201	1100	<u></u>			

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

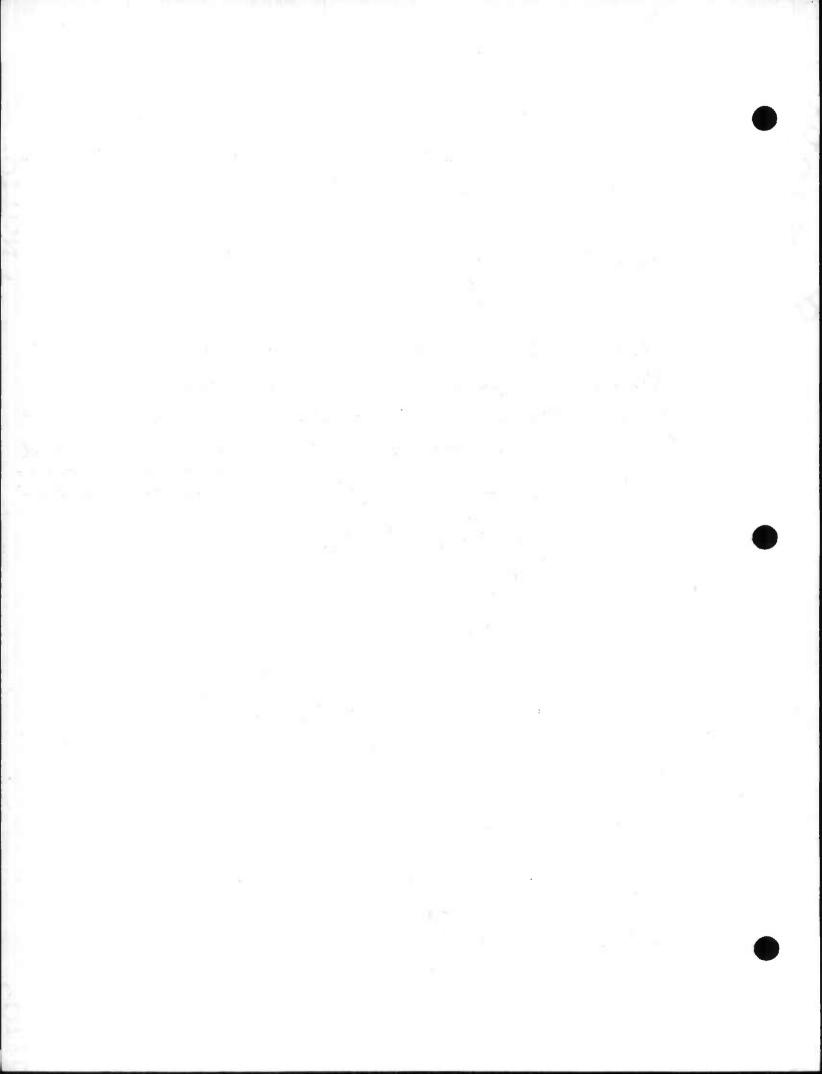
TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with. Nous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_	REGISTRAR	CER	TIFICATE (OF DEATH	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	Mooki			2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birth	"	AR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Pountry)
~	9e. FACILITY, NAME (If not institution, give street and num	00		WN OR LOCATION OF DE	ATH 9c. CO	UNTY OF DEATH
20	RESIDENCE OF DECEDENT	HOSPITAS	/3	sa Itimor	re	
DIRECTOR	10e. STATE 10b. COUNTY	10-	c. CITY, TOWN OR L	timore		10d. INSIDE CITY LIMITS? 1 A YES 2 NO
FUNERAL	100. STREET AND NUMBER 222 N. Deni	son St		10f. ZIP CODE 2/2	2-29 10g. CI	TIZEN OF WHAT COUNTRY?
	11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS D FORCE	ECEDENT EVER IN U.S. ARMED ES? 1 YES 2 NO , GIVE WAR OR DATES	13. WAS	DECENDENT OF HISPAN s, specify Cuben, Mexice YES 2 NO Specify		14. RACE — American Indian, Black, White, atc.
D BY	15. DECEDENT'S EDUCATION	160 DECEDE	PAC I	PATION	18b. KIND OF BUSINESS/IN	MACK
PLETED	(Specify only highest grade completed)	(Give kii	nd of work done durin	g most of working	Laur E	a-force ment
COMPL	17. FATHER'S NAME (First, Middle, Last)	70.	uty 21	18. MOTHER'S NA	ME (First, Middle, Maiden Surname)	Ma cement
BE	190. INFORMANT'S NAME (Typa/Print)	reckin 19b. MA	ALING ADDRESS (S)	eet and Number or Rural I	C Strange	hter
임	Alice P. Mª Me	ekin 2:	22 N.	Denison	n St. Batto	Md. 21229
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Removal from S Donetion 5 Other (Specify)	tate 20b, PLACE AND Cometery, cremator	DATE OF DISPOSITION OF OTHER PROPERTY OF THE P	est Vet 12	19/94 OWEN	as Mills, Mol
	21. SIGNATURE OF FUNERAL SERVICE LICENSES	Call	22. NAM	E AND ADDRESS OF FA	Caple Fu	neral Service
-	23. RART L Enter the diseases, or complication	one that caused the death.	Do not anter the	mode of dyling, auc	ner Ave S	rrest, Approximata
	ahock, or heart failury. List only of IMMEDIATE CAUSE (Final disease or condition	ona cause on each lina.	0			Interval Batween Onset and Death
ļ	reaulting in death)	DUE TO (OR AS A CONSTILLEN	e Ke)	nal Fo	ailure	242
NO	Sequantially list conditions,	Periphera DUE TO (OR AS A CONSEQUEN		cular.	Dz	years
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.	Dia bete:	S Mt	Mita	5	
ERTIF	that initiated eventa resulting in death) LAST	Sepsis	OF):			
5	PART II. Other significant conditions contribu	iting to death but not resul	ting in the under	lying cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICA					1 TYES 2 NO	COMPLETION OF CAUSE OF DEATH?
Z	DID TOBACCO USE CONTRI	IBUTE TO CAUSE	OF DEATH	YES NO		1 Tes 2 No
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 I Input	TAL: ent 2 ☐ ER/Outpetient 3 ☐ D	OTHER:	8. PLACE OF DEATH (Ch		
H	27. MANNER OF DEATH 280. I			Home 5 Residence INJURY AT WORK?	28d. DESCRIBE HOW INJURY O	CCURED
à	2 Accident Investigation 3 Suicide 28e. F	PLACE OF INJURY — At home, 1 building, etc. (Specify)		YES 2 NO	281. LOCATION (Street and Numb	er or Rural Route Number,
	4 Homicide determined				City or Town, State)	
COMPLEIED	(Check only 1 CERTIFYING PHYSICIAN: To the					ated. the ceuse(s) end manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	modizal	Mar Day	29c. LICENSE NUM	IBER 29d. DA	TE SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLET	ED CAUSE OF DEATH (ITEM 27)	(Type, Print)	71100	101	12/5/17
	31. DATE FILED (Month, Oay, Year) 32. RI	EGISTRAR'S SIGNATURE	Balt.	VAM	ed Ctr-	
	DECU 9 1994 Julia draw	olion Ravdall				



BALTIMORE, MARYLAND	aw requires that the death certificate be executed with
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L RECORDS, P.O. BOX 68760,	sertificate be
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	1 - STATE REGISTRAR			CATE OF DEATH	H REG. NO.	
1	1. DECEDENT'S NAME (First, Middle, La.		ICHAL		2. DATE OF DEATH	SEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	F UNDER 1 YEAR F UNDER 24	HRS. 7. DATE OF BIRTH (Morrith, Day, Ybar)	8. BIRTHPLACE (State or Foreign Country)
(B)	NACILITY NAME (If not institution, give	e street and number)	+ Home	96. CITY, JOWN OR LOCATION		9c. COUNTY OF DEATH
ривестря	RESIDENCE OF DECEDENT 10s. STATE 10s. COU	N/A		TOWN OR LOCATION altimore	3,20	10d. INSIDE CITY LIMITS?
11,000	100. STREET AND NUMBER 521 S. Caton Av			101. ZIP CODE	00	1 ☑ YES 2 ☐ NO 10g. CITIZEN OF WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed Divorced	12. WAS DECEDENT EVE FORCES? 1 YES, GIVE WAR OF	R IN U.S. ARMED	If yes, specify Cuban,	HISPANIC ORIGIN? (Specify Yea Mexican, Puerto Rican, etc.) Specify:	U e S e A e or No— 14. RACE — American Indian, Black, White, etc. Specity:
	15. DECEDENT'S E		16a, DECEDENT'S U	SUAL OCCUPATION	16b. KIND OF BUSI	White
COMPLETED	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of we life. Do NOT use House	ork done during most of working retired.)		N/A
CON	17. FATHER'S NAME (First, Middle, Last)		110000		R'S NAME (First, Middle, Maiden S	Sumame)
BE (James Thumle	rt			Nettie Twigg	
5	19a. INFORMANT'S NAME (Type/Print)				r Rural Route Number, City or Town	
	Linda C. Dunkl		1521 S.		Baltimore, Md.	
	29s. METHOD OF DISPOSITION 13. Burlel 2 Cremation 3 R 4 Donation 5 Other (Specify)		cemetery, crematory or oth	er place)		CATION — City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE		Loudon Par	k Cemetery 12		to. Md.
	G. Truman	Sohuah			imore National	Pike
	23. PART I. Enter the diseases,		sed the death. Do no	Baltimore	Md. 21229	atory arrest, Approximete
	shock, or heart failur iMMEDIATE CAUSE (Final disease or condition resulting in death)	e. List only one cause of	n each lina.	De cub, hu		interval Betwee
NO	Sequentially list conditions,	b	S A CONSEQUENCE OF)	Respirat	ory faile	uno monte
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	C	S A CONSEQUENCE OF)	In ha Co	uni P blas	ed mout
ERTIF	that initiated events resulting in death) LAST	d.	S A CONSEQUENCE OF)	Seps: 5		Days
LC	PART II. Other aignificant condit	iona contributing to deat	h but not resulting in	the underlying cause give		
: MEDICAL	premie	Slizne	Disol	le,	PERFORI	MED? AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
SICIAN:	25, WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHERM	ATH (Check only one)	
PHYSICI	27. MANNER OF DEATH	1 Inpatient 2 ER/C 28e. DATE OF INJUR (Month, Day, Yes	TY 26b, TIME		28d. OEŞCRIBE HOW IN	JURY OCCURED
D BY	2 Accident Investigation 3 Suicide 6 Could not determined	26e PLACE OF IN.II	JRY — A1 home, farm, st Specify)			nd Number or Rural Route Number,
ED		VOICHAN, We she had ad any har	rowledge death province	at the time, date and place, a	and due to the cause(s) and men	ner as stated,
ᇤ						
BE COMPLETE	(Check only CERTIFYING PH	INER: On the basie of examina		, in my opinion, death occured	at the time, date and place, and	due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)



DEC 0 9 1994

REGISTRAR'S SIGNATURE

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. fours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR

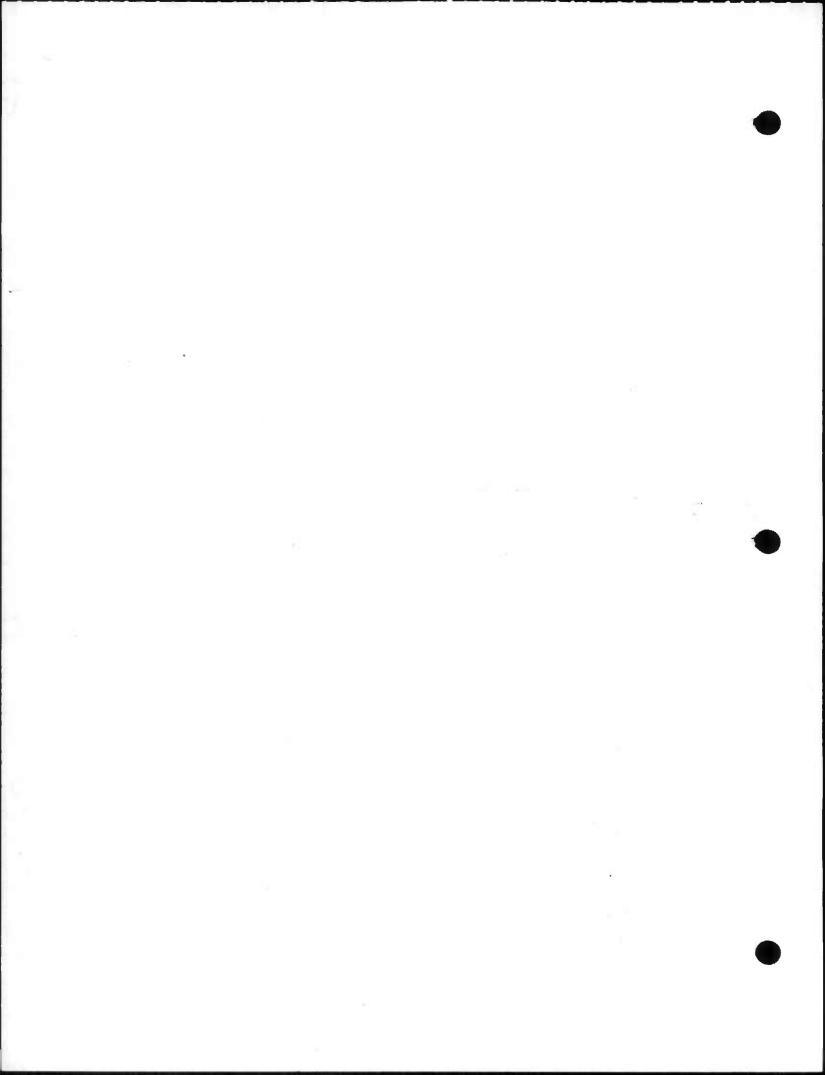
1 - STATE REGISTRAR	STATE OF				F HEALTH AND OF DEATH	MENT	AL HYGIEI			
1. DECEDENT'S NAME (First, Middle, Myra Sherber	t Morela						TE OF DEATH	1994	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 213-22-0957	5. SEX	6. AGE (In yrs. 99	last birthday) YRS.	IF UNDER 1 Y	EAR IF UNDER 24 HRS. AYS HOURS MIN.	7. DAT	onth Day, Vear)	95	Country	PLACE (State or Foreign y)
Sa. FACILITY NAME (If not institution,	give street and number)			96. CITY, TO	OWN OR LOCATION OF I			_	NTY OF D	_
Meridian Nursi	_			Annar	polis			Ann	e A	rundel
10e, STATE 10b, C	DUNTY ne Arund	el		, TOWN OR I	OCATION					10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER			Гос	hian	101. ZIP CODE			100 CIT	TEN OF V	1 X YES 2 NO
310 Frank Mo	reland P	lace			20711			US		VIIAI COUNTRIT
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	ENT EVER IN U.S. 1 YES 2 YES 2 YEAR OR DATES		If ye	B DECENDENT OF HISP/ es, specify Cuban, Mexic YES 2 NO Spec	an, Puarl	GIN? (Specify Ye to Rican, atc.)	a or No—	Black	- American Indian, K, White, aic.
15. DECEOENT': (Specify only highest Elementary/Secondary (0-12)	B EDUCATION grade completed) College (1-4 or	5+)	DECEDENT'S (Give kind of w life. Do NOT us	vork done durii e retired.)	PATION ng most of working	1	66. KIND OF BU		DUSTRY	m o
17. FATHER'S NAME (First, Middle, La	ef)	111	Jusew	TIE	40 1107117710 11	1000			по	me
John Wayson	- 7	t Sr.			Julian				7	
19a, INFORMANT'S NAME (Type/Print)		196. MAILING	ADDRESS (S	treet and Number or Rura			- 4		
Elgin K. Mor	eland				Morelan					
20e. METHOD OF DISPOSITION Surial 2 Cremation 3 4 Donetion 5 Other (Specify,	Ramoval from Stata		E AND DATE OF COMMENTS OF COMM		• Cemete:	ry 1	12/8	CATION —		mn, State n, MD
21. SIGNATURE OF BUNERIAL SERVI	CE LICENSES,	//		22. NAI	ME AND ADDRESS OF F	ACILITY				
Dalah)	f amold	h		12	Ridgely	Ave	e. Anr	apol	is,	
23. PART I. Enter the discosts shock, pr hear fel immediate CAUSE (Final disease or condition resulting in death)	fure. Liet only one c	euse on eech ii	ne.		e mode of dying, au			oiretory an	reet,	Approximata interval Between Onset end Deeth
Sequentielly list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Discess or injury that initiated eventa resulting in death) LAST	c	O (OR AS A CONS								
PART ii, Other eignificent con	ditiona contributing	to deeth but no	t recuiting i	n the under	rlying ceuse given is	n Part I.	24a, WAS AI	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
Counties	of other	oscler	nis.			_	1 TYES	. /		AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
DID TOBACCO USE CO	ONTRIBUTE TO C	AUSE OF DE	ATH YE	S NC	UNCERTA	IN 🗆			`	1 123 1 2 10
25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:		ACE OF DEAT	N (Check only	one)					
1 YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2	☐ ER/Outpatient OF INJURY	3 DOA	Nursing	Nome 5 Residence		ther (Specify)	IN HIRY OC	CIBER	
1 Natural 5 Pending 2 Accident Investige	(Month,	Day, Year)	INJ	M 1	WORK?	200. 0	CONIBE NOW	MJUHT OCI	CONED	
3 Suicida 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
	PNYSICIAN: To the best) and manner as stated.
296. SHERASURFAND TITLE OF CER	Vinze	r M	\mathcal{D}		DO5	MBER 92	8	29d. DAT	e signed	(Month, Day, Year)
1833 A F	rest Dr	We A	TEM 27) (Type,	po lis	MD2	14	01			
31. DATE FILED (Month, Day, Year)		RAR'S SIGNATURE	V	0 - 0	- 1-	, ()				
UEUU 9 1994	Telia Davideo	Kardall								DHMH-16 Rev 1/89

ospital or attending physician. thed for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OF THE FUNCTION IN INC. WITH ORTA TO THE	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hosp TO THE FUNCTAL INSTITUTE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled with the hours are death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTALE II have 25 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPART				GIENE		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DI	EATN	1000	3. TIME OF DEATH
	SARAH	JANE MOORHEAD				Dec.	6 1	994	2:45 A M
				IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BII (Month, Day,	Year)	Count	HPLACE (State or Foreign ry)
	164-22-8569 9e. FACILITY NAME (If not institution, give stre-	1 🗆 M 2 💢 F	66 YRS.			May 20	1928		nsylvania
Œ	6636 Whitmore Ct	,		Glen E	PR LOCATION OF DE	EATN		OUNTY OF D	
CTO	RESIDENCE OF DECEDENT	. Apt. 133					I A	ппе А	rundel
E	Many land Ann	a Anunda I	10c. CITY,	TOWN OR LOCAT					10d. INSIDE CITY LIMITS?
L D	Maryland Anne	e Arundel		Glen E	ZIP CODE		40- 0	TITEN OF I	1 TYES 2 NO
FUNERAL DIRECTOR	6636 Whitmore Ct.A	APT. 153		"	21061		log. C	USA	HAI COONINY?
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF NISPAN	VIC ORIGIN? (Spe	ecify Yes or No-	14. RACI	E American Indian,
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 TYES			2 NO Specify		etc.)	Spec	k, Whita, etc.
	15. DECEDENT'S EOUCA	TION I	18e. OECEDENT'S U	RUAL OCCUPATIO	N	40. 1/10/0	OF BUSINESS/I	VALUE TOWN	"Mhite
COMPLETED	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of wo	rk done during mo	st of working	TOD. KIND	OF BUSINESS/I	NOUSTRY	
MPL	10		Factory	Worker	•	Sev	wing C	lothi	ng
8	17. FATNER'S NAME (First, Middle, Last)		0		18. MOTHER'S NA	ME (First, Middle,	Maiden Surname)	
B		ruce	Gorman		Eva	Grace		owell	
2	19a. INFORMANT'S NAME (Type/Print) Ralph Moorhead				nd Number or Rural I				Md.21061
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE OF				20c. LOCATION		
	1 Buriel 2 CCremetion 3 Ramovi	al from State	etro Crematow or other	atory I	nc.			-	Maryland
	21. SIGNATURE OF FUNEBAL SERVICE LICEN			22. NAME AN	O ADDRESS OF FA	CILITY		<u>,</u>	ria. y rana
	* Lal J	W H		Stall	ings Fun Mountain	eral Ho	ome PA	Md	21122
	23. PART I. Enter the diseases, or collector, or heart fallure. Lis	mplications that caused	the deeth. Do no	t enter tha mo	de of dying, suc	h as cardiac o	r respiratory	rrest,	Approximate
	IMMEDIATE CAUSE (Final	y only one ceuse on se	cn nne.	/					interval Between Onset and Death
	disease or condition resulting in death) e.	Caren		Kin	/				4 ments
_		DUE TO (OR AS A	CONSEQUENCE OF):		X.				
CERTIFICATION	Sequentially list conditione, if any, leeding to immediate	DUE TO (OR AS A	ONSEQUENCE OF:	- '				-	
CAI	cause. Enter UNDERLYING CAUSE (Disease or injury		/						
E	thet initiated evente resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):						
SER	d.								
AL	PART II. Other significant conditions	contributing to deeth bu	t not resulting in	the underlying	ceuse given in		WAS AN AUTOPS PERFORMED?	Y 24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIC							YES 2 NO		COMPLETION OF CAUSE OF DEATH?
ME									1 Tes 2 No
BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH		UNCERTAIL	<u> </u>			
Sici	EXAMINER?	HOSPITAL:		THER:	5 Rasidence	a [] au _ (a			
Ή	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJ	URY AT		HOW INJURY O	CCURED	
×	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUF		RK? ES 2 NO				
	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJURY - building, atc, (Specif	— At home, farm, stre	et, factory, office		281. LOCATION City or Town	(Street and Numb n, State)	er or Rural F	Route Number,
COMPLETED	an communa								
F V		AN: To the best of my knowle							
ਰ		On the basis of axamination	end/or investigation,	in my opinion, de			lace, end dua to	the cause(s) end manner es stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIER	m-	7		29c. LICENSE NUN	IBER	29d. D/		(Month, Day, Ybar)
2	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TN (ITEM 27) (Type. Pi	rint)	D39505			12/8/	/94
	Yudhishtra Marka	1	rain Hwy		Burnie	Md. 210	61		
	DECU 9 1994	32. REGISTRAR'S SIGNA	TURE	- 41011	Dai III Co	<u> </u>	V I		
	DEC 9 1994 A	ya d'aucher has	dall						1



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death, Page 6 may be retained by the hospital or attending physician.

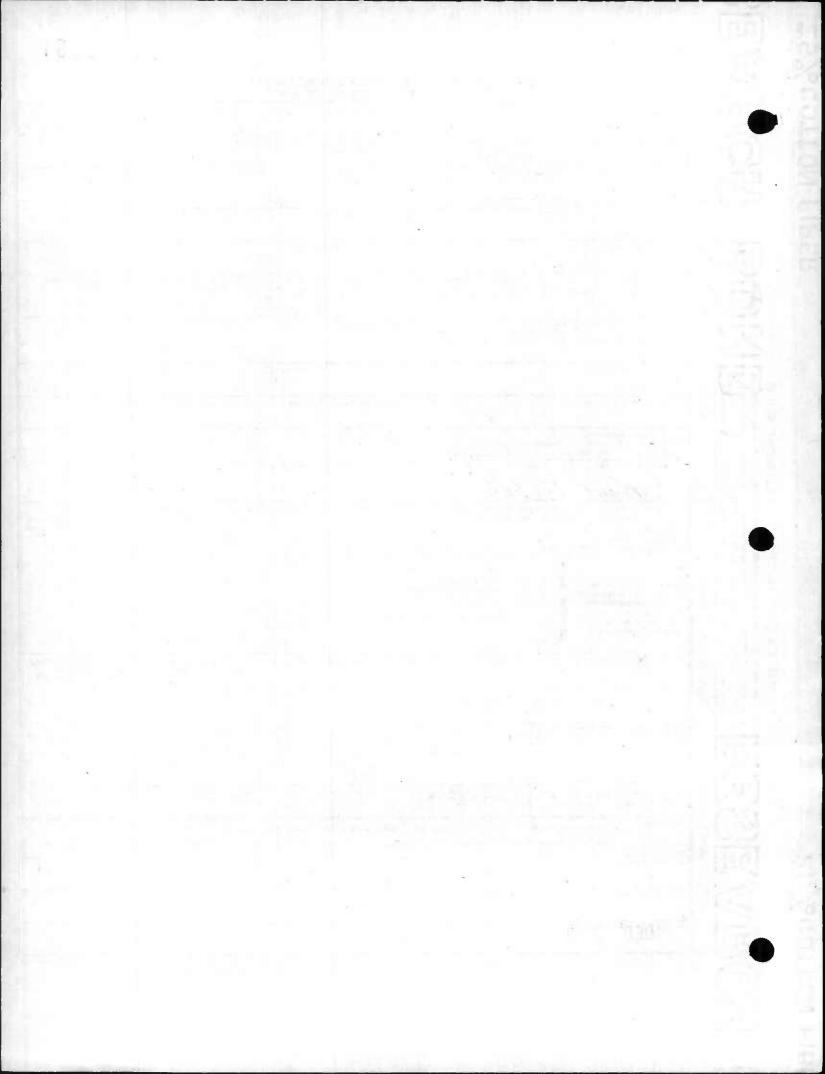
IN DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			IENTAL HYGIEN		
Contractors	1. DECEDENT'S NAME (First, Middle, Last) John Joseph	n McGraw			ID ID	2. DATE OF DEATH ON ecember 3	, 1994 YEAR	3. TIME OF DEATH 11; 10 A. M
STONE STONE	4. SOCIAL SECURITY NUMBER 214-05-7336	1X M 2 □ F 79	YRS.	F UNDER 1 YEAR ONTHS DAYS	HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) July 11,19	915 Cun	on the Lace (State or Foreign Intry) on berland, Md.
HC.	90. FACILITY NAME (If not institution, give since the second of the seco	freet and number) fanor Nursing			R LOCATION OF OEA LSterstow		9c. COUNTY OF Bal	timore
DIRECTOR	RESIDENCE OF DECEDENT 10+. STATE 10b. COUNTY		10c. CITY, T	TOWN OR LOCAT				10d. INSIDE CITY
		Baltimore			isterstow	n		1 Tyes 2 H NO
FUNERAL	9 Fox Run Cour	t		101	ZIP COOE	136		SA
Β¥	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN (FORCES? 1 TO YES IF YES, GIVE WAR OR DATE WAS IT	2 NO	If yes, sp	ENDENT OF NISPANI polity Cuban, Mexicon, 2 NO Specify:	C ORIGIN? (Specify Yee, Puerto Rican, etc.)	Ble	CE — American Indian, ack, White, atc.
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) High School		16a. DECEDENT'S US (Give kind of work life. Do NOT use n State	k done during mo etired.)	st of working		siness/industry	
OME	17. FATHER'S NAME (First, Middle, Last)			- mary		E (First, Middle, Maiden		rence
BE C	John P. M	lcGraw				ry Bahen		
5	Mrs. Jean C. McG	raw		Run Cou		oute Number, City or Town		21136
	20s. METNOO OF DISPOSITION 1 Disposition 3 Remotion 3 R	oval from State	PLACE AND DATE OF	DISPOSITION (Na	me of	DATE 20c. LO	CATION — City or	
	4 Donetion 5 Other (Specify)	-51	Anthon	y s_Cer	netery	12/6/94		and, Md.
	Samo B	& line			Funeral	118		sterstown Rd. own, Md. 2113
NC	23. PART I. Entar the diseases, or on shock, or heart failura. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisity list conditions,	a. Atastal DUE TO (OR AS A C	ch lina. COUSCONSEQUENCE OF): Tion				retory arreat,	Approximata Interval Between Onset and Daath
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated aventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PHYSICIAN: MEDICAL	PART II. Other significant condition	s contributing to death but	t not raaulting in 1	the underlying	j cauaa givan in P	24s. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO
N.	DID TOBACCO USE CONTI				UNCERTAIN			
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inputient 2 ER/Output		THEM:	5 🗆 Residence 6	[] 04 (04-)		
	27. MANNER OF OEATN 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	OF 28c. INJ Y WO		28d. OESCRIBE HOW IF	NJURY OCCURED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY - building, etc. (Specify	- At home, farm, stre			281, LOCATION (Street e City or Town, Stelle)	and Number or Rure	il Route Number,
29e. CERTIFIER (Check only one) 1 DEFITIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(e) end menner es stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause								
TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIES	Halres M			29c. LICENSE NUME			ED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHI	itty Pr	Heisin	int) PA	ek le	stersle	runj	2/13/6
	UEC (19 1054	HERSTIAN'S SIGNAL	Nardall					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 2. DATE OF OEATH LAL 3. TIME OF DEATH Orlando 30 24 Pedroso 12:20/H 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. BIRTHPLACE (State or Foreign (Month, Dev. Year) 031 60 0740 59 HOURS 1X M 2 | F 5-5-1935 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH SC COUNTY OF OFATH BALTIMORE DIRECTOR CHURCH HOSPITAL 1.2 RESIDENCE OF DECEDENT Pages 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 YES 2 NO permit. FUNERAL 104 STREET AND MIMBER 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit no fixed address attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1F YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: Poss: Puerto Rico White COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) hospital or detached for Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) retained by the a Ħ BE notified a funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 5 Page 6 may be -20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donation 5 Other (Specify) in state removal an SIGNATURE OF FUNDMAL SERVICE LICENSEE Ronald Wade, Dir examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board death. 655W.Baltimore St, Balto, MD21201 filled in by the fu medical 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate ahock, or heert failure. Liet only one ceuse on each line interval Between IMMEDIATE CAUSE (Final Onset and Desth the disease or condition cremation, an and completely fill to burial, cremation NEUMONIA WKS resulting in deeth) event. DUE TO (OR AS A CONSEQUENCE OF) the death certificate be executed 105 traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate the attending physician I Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significent conditions contributing to death but not recuiting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS been signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 TYES 2 NO PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OR ATTENDING PHYSICIAN: The I 26. PLACE OF DEATH (Check only one) certificate t OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) HOSPITAL: 1 TES 2 NO 1 N Inpetiant 2 ER/Outpatient 3 DOA 6 27. MANNER OF DEATH 26b. TIME OF 26a, DATE OF INJURY 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mari BY Investigation 2 Accident 3 Sutcide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town State) 6 Could not be determined COMPLETED 4 Homicide FUNERAL DIREC within 72 hours of TANT: If Item 2 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 30 arem m 3 2 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE DECONTO, DO H1994 27. REGISTRAR'S SIGNATURE alia Denden-Rendald

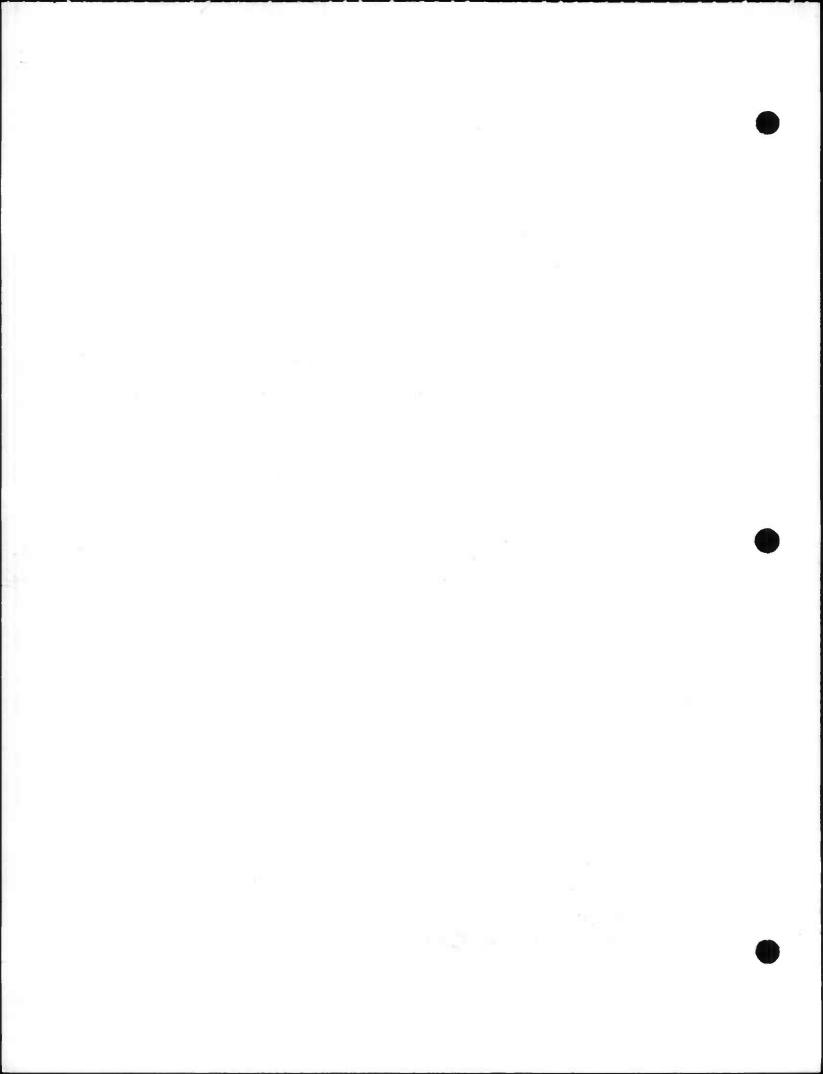


BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	tion, or removal.
OF VITAL RECORDS, P.O. BOX 68760,	e executed within	an and completely	the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.
P.O. BO	th certificate b	ending physici	I Hygiene prior
JRDS, I	that the deat	ed by the atte	h and Mental
- RECC	aw requires	s been signe	of Health
VI A	CIAN: The Is	ertificate has	the State De
j Z	G PHYS	er this c	ath/with
SISIO	A ACTENDRA	RECTOR AN	use after des
3	SPITAL G	NERAL D	thin 72 ho.
	TO THE HC	TO THE FU	be filed wit

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1						7611111	IONIL	01	DEATH		HEG. NO	, <u> </u>		
		1. DECEDENT'S NAME (First		70 7	•					- 1	2. DATE OF DEATH	AY	YEAR	3. TIME OF DEATN
		Ro		Polan	ld				_	1	Dec 07,	1994		м
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER		IF UNDER 24 I	_	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTH	NPLACE (State or Foreign
İ		025-24-4861		1 X M 2 🗌 F	62	YRS.	MONTHS	DAYS	HOURS N	IIN.	April 5,	1932		ssachusetts
		9e. FACILITY NAME (If not in	nstitution, give s	treet end number)			9b. CITY,	TOWN (OR LOCATION				NTY OF D	DEATH
	R	2 Gurteen C	Court.	#302			Tim	oni	ıım			B	altin	nore
	DIRECTOR												4101	
	#	10e. STATE	10b. COUNT			10c. CI1	Y, TOWN O							10d, INSIDE CITY LIMITS?
		Maryland		timore			Timo	niu	ım					1 - YES 2 1 NO
	FUNERAL	10e. STREET AND NUMBER				101. ZIP CODE					10g. CITIZEN OF			WHAT COUNTRY?
	ij l	2 Gurteen	Court	<i>,</i> # 302					21093			U	SA	
	5	11. MARITAL STATUS	and the state	12. WAS DECEDEN	T EVER IN U.S.	VER IN U.S. ARMED YES 2 NO 13. WAS DECENDENT OF NISPANIC If yee, specify Cuben, Mexican,					ORIGIN? (Specify Ye	e or No-	14. RACI	E — American Indian, k, While, etc.
	ВУ	1 Never Married 2 X			WAR OR DATES						Paerto Ricent, etc.)		Spec	tty:
ļ				1										White
ı	ш	(Specify only	EDENT'S EDU y highest grade	completed)		DECEDENT'S (Give kind of	work done di	CUPATIO Iring mo	ON ast of working		16b. KIND OF BU	SINESS/IN	DUSTRY	
	COMPLET	Elementary/Secondary (0	0-12)	College (1-4 or 5	+)	life. Do NOT u	-				Sanitar	v 14/5	cto	Equip
93	M	17. FATHER'S NAME (First, M	148 4 0	4	M	echan:	ical	Eng				<u> </u>	Ste	rdaib.
at once.									(First, Middle, Melder					
60	H	Frank 190. INFORMANT'S NAME (7)	Po1		_		Jes				Bland	<u>d</u>		
be notified	2	Mrs. Annie		land	1						ite Number, City or Tov			20
9				Lanu				_		۷,	Timonium,		2109	
tan		20e. METHOD OF DISPOSITION 1												
- 10	Ì	4 Donation 5 Other (Specify) Greenlawn Mem. Gardens Dec Fuquay-Varina, N.C.												
盲		Lemmon Funeral Home												
event, the medical examiner must	-	Bryan	W. Cla	- 4	1		1	0 W	. Pado	nia	Road, Ti	moni	ım. l	4D 21093
dica		23. PART I. Enter the di	isesses, pr	omplications the	t caused tha	death. Do	not anter t	ha mo	de of dying,	such a	sa cardiac or resp	iratory ar	rast,	Approximate
Ē	23. PART I. Effer the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final											Interval Batwesn Onset and Death		
th.		disesse or condition resulting in dasth)	→	45	nate	0-	1711	UL	Me					4 mm
vent	1													
tic e	z	Sequentially list conditions, b. Mc ASTATIC Small Cell Lung Carcengriz year												
traumatic	CATION	If any, leading to immediate												
		CAUSE (Disease or Injury												
other	E 1	that initisted events DUE TO (OR AS A CONSEQUENCE OF): resulting in dasth) LAST												
6	CERTIFI	resulting in dastn) LAS		d										
Injury,		PART II. Other significa	int condition	s contributing to	dasth but np	t reaulting	in the unc	larivino	causa olva	n in Pa	irt I. 24a, WAS AN	ALITOPSY	245	. WERE AUTOPSY FINDINGS
any l	CAL								10	_	PERFO	RMED?	1 30	AVAILABLE PRIOR TO COMPLETION OF CAUSE
WS 3	Ě										_ 1 _ YES	NO NO		OF DEATH?
8	Σ	DID TOPACCO II	SE CONT	DIDLITE TO CA	UCE OF DE	ATLL M			1		_			1 TES 2 NO
23	PHYSICIAN:	DID TOBACCO U		RIBUTE TO CA		ACE OF DEA		_	UNCER	IAIN				
Item	을 다	EXAMINER?		HOSPITAL:			OTHER		**					
28 is marked, or	¥	27. MANNER OF DEATH		1 Inpatient 2 I		28b. TIN		ng Nom			Other (Specify)	N HITT OO	OUDED	
rked	- 1	1 Natural 5	Pending	(Month, D			IURY M	WO	RK?	_	ed. DESCHIBE HOW	NJURY OC	CUHED	
E	B	2 Pulate	Investigation	28e. PLACE O	F INJURY — At	home farm	street lector				AL LOCATION (St	and Alcordon	0	2
182			Could not be determined	building,	etc. (Specify)	nonne, tattiti,	street, tector	y, office		1	8t. LOCATION (Street City or Town, State	and Number	or Hurai F	loute Number,
	1 1	29e. CERTIFIER			-									
If Item	COMPL	(Check only									the cause(s) end ma			~ 1001100470001
IMPORTANT:	8				xamination end/o	r Investigatio	en, i <i>n m</i> y op	Inlon, d	eath occured a	t the tim	ne, date end place, er	d due to th	re ceuse(e	end manner ee stated.
F	BE	296. SIGNATURE AND TITLE	OF DEBYIPTER	/ _		10			29c. LICENSE			29d. DAT	E SIGNED	(Month, Day, Year)
割	2		4/	1 AU	ms	10	D		V 3	36.	24	I	Dec 7	, 1994
V		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
1		John C. Downs, M.D. 7505 Osler Dr., suite 504, Towson, MD 21204												
		31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SIGNATURE DEC 0 9 1994												
L		DEC 4 3 13	34 Ja	NA WWW.	rareau									
			11950											



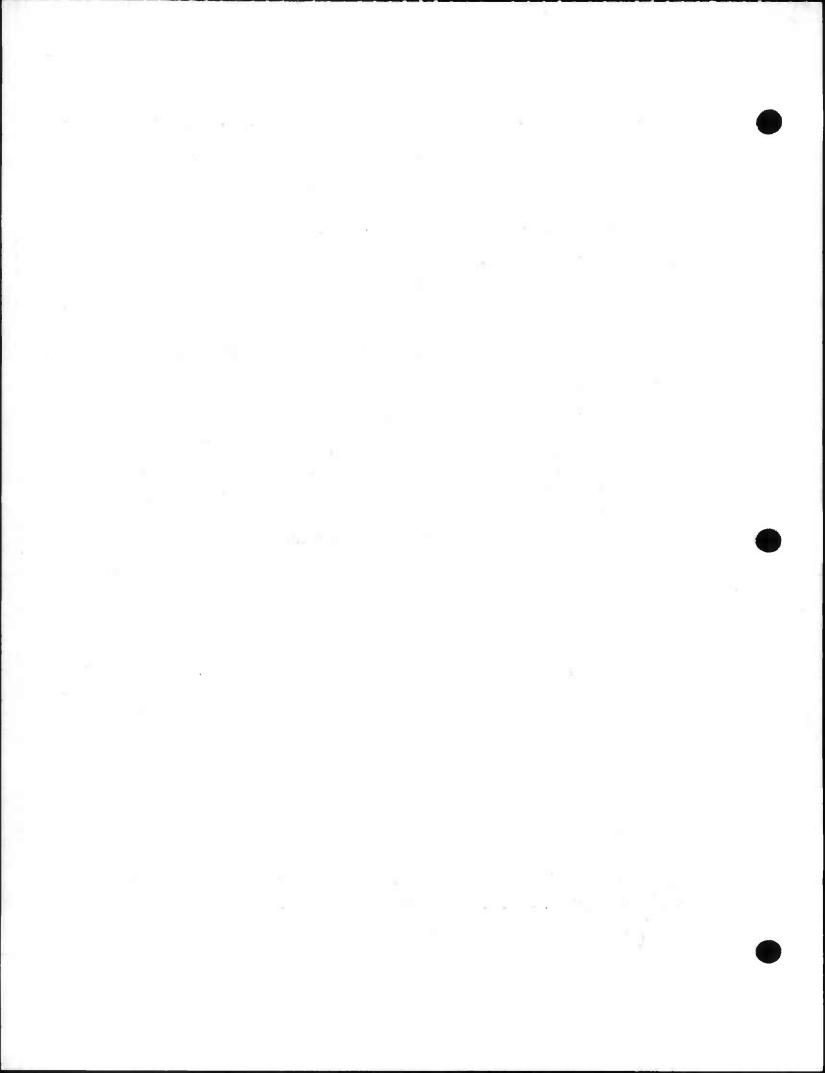
BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	DECOME Are this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	on ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	ILECTOR: Are this certificate has been signed by the attending physician and completely fills

To the Arer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the state begr. of Health and Mental Hygiene prior to burial, cremation, or removal.

The 28 is marked, or filem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. ATTENDING PHYSICIAN: The law requires that the death certificate

STATE OF MARYLAND / DEPARTMENT DF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG. NO.

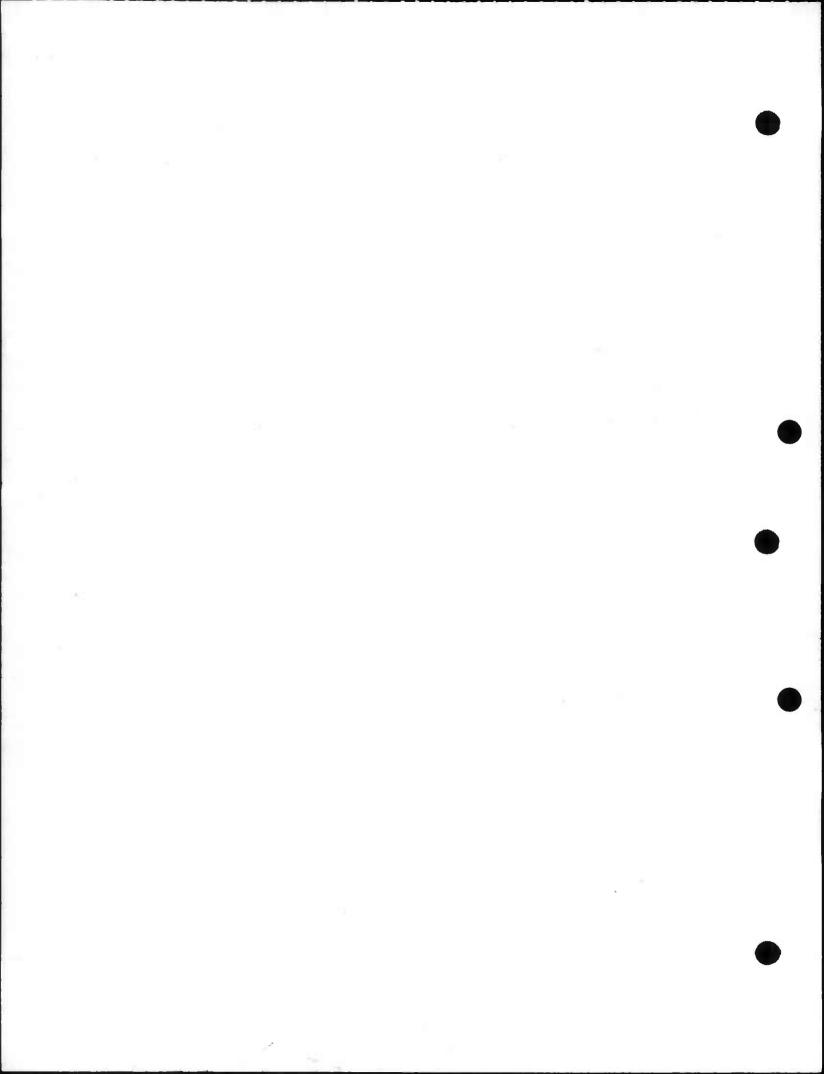
	1 - FOR STATE (F MARYLAND / DE	EPARTMENT DF H	EALTH AND ME	NTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last) Alvin O.	Pome	erance		DATE OF OEATH	YEAR 8:15 P M
	4. SOCIAL SECURITY NUMBER 5. SEX 146 10 6507				DATE OF BIRTH	6. BIRTHPLACE (State or Foreign New Jersey
OR	99. FACILITY NAME (If not institution, give street and number 7320 Rocky Road	7)	96. CITY, TOWN C Layto	nty of DEATH Ontgomery		
DIRECTOR	100. STATE 100. COUNTY Maryland Montgome:		Cily, TOWN OR LOCAT			10d. INSIDE CITY
	10e. STREET AND NUMBER		Silver Sp		LIMITS? 1 YES 2 NO TIZEN OF WHAT COUNTRY?	
FUNERAL	15101 Interlachen D. 11. MARITAL STATUS 12. WAS DEC	EDENT EVER IN U.S. ARMED 1 YES 2 2 NO		20906 ENDENT OF HISPANIC O	ORIGIN? (Specify Yee or No-	ed States
BY		1 YES 2 2 Mb	It yee, sp 1 — YES	cify Cuben, Mexicen, Pr		Caucasian
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4)	or 5+) (Give ki	PENT'S USUAL OCCUPATION ind of work done during mo NOT use retired.)	DN st of working	16b. KIND OF BUSINESS/IN	DUSTRY
MPL	17. FATHER'S NAME (First, Middle, Lest)	Sale	esperson		Printing	
BE CC	Hyman Pomerantz			Rose Oli	First, Middle, Malden Surname)	
TO	190. INFORMANT'S NAME (Type/Print) Fannie Pomerance	19b. M/ Sa	alling address (Street a	nd Number or Rural Route SS as #10	Number, City or Town, State, Zij	p Code)
	20a. METHOD OF DISPOSITION 1 → Burlel 2 □ Cremetion 3 □ Removal from Stat 4 □ Donetion 5 □ Other (Specify)		DATE OF DISPOSITION (Na		20c. LOCATION — 1994 Olne	City or Town, State
	21. SIGNAPHRE OF FUNERAL SERVICE LICENSEE				Y Funeral H	
	23. PART Entar the diseases, or complications shock, or heart failure. List only one	that caused the death.	. Do not entar tha mo	de of dying, such as	cardiac or raspiratory ar	rast, Approximata
	iMMED(ATE CAUSE (Final disease or condition resulting in death)	rebrovascu	lar accid	lent		immediate
_	DU	E TO (OR AS A CONSEQUEN	NCE OF):			
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	E TO (OR AS A CONSEQUEN	NCE OF):			
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting In death) LAST	E TO (OR AS A CONSEQUEN	NCE OF):			
ابا	PART II. Other significant conditions contributing		Iting in the underlying	causa givan in Pari	t I. 24a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICA	Alzheimer's Dement	cia			PERFORMED? 1 Tres 2 No Brain	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN:	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL		YES NO DEATH (Check only one)	UNCERTAIN [
PHYSICIAN:	EXAMINER? YY HOSPITAL			5 Residence 6	Other (Specify)	
BY PH		E OF INJURY (th, Day, Year)		JRY AT 266 RK? ES 2 NO	I. DESCRIBE HOW INJURY OC	CURED
ETED E	3 Suicide a Could set 28e. PLA	CE OF INJURY — At home, tiling, atc. (Specify)	term, street, tectory, office	281	LOCATION (Street and Number City or Town, State)	r or Rural Route Number,
COMPLE	29e. CERTIFIER (Check only one) 2 CERTIFYING PHYSICIAN: To the belief					
BE	29b. SIGNATURE AND TITLE OF CERTIFIED WHO I CHARLE THE	0	M.D.	29c. LICENSE NUMBER	29d. DAT	E SIGNED (Month, Day, Year) 6-94
10	30, NAME AND ADDRESS OF PERSON WHO COMPLETED MICHAEL ANCHORS, M. I		*	Md.		
	31. DATE FILED (North, Day 1994 July 34 REG	TRARES GH TUPE				



21215-0020	
MARYLAND	
BALTIMORE,	
3760	

DIVISION OF VITAL RECORDS, P.O. BOX 68

	REGISTRAR		CER	TIFICA	E OF	DEATH	RE	G. NO.				
	1. DECEDENT'S NAME (First, Middle, La BRENDA	PRIDE					2. DATE OF D	EATH DAY	94	3. TIME OF DEATH 9.05A		
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. lest birt	hday) IF UNI	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI (Month, Day)	RTH Marri	8. BIRTHE	LACE (State or Foreign		
	216-42-2855	1 □ M 3(1) F	י 50	rs.	B DAYS	HOURS MIN.	07-22	2-44	M			
_	9a. FACILITY NAME (If not institution, gir			9b. CI	TY, TOWN C	R LOCATION OF DE	EATH	9c. C	DUNTY OF DE	ATH		
RECTOR	NORTHWEST HO		NTER		BALTIMORE							
<u> </u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COU		10	e. CITY, TOWI	OR LOCAT	1	10d. INSIDE CITY					
	MD BA	LTIMORE								LIMITS? 1 TYES 25 TYNO		
	10e. STREET AND NUMBER				101	ZIP CODE		10g. (AT COUNTRY?		
FUNERAL	3727 CEDAR D	RIVE				21207			S.A.			
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED	1	3. WAS DEC	ENDENT OF HISPAN	ecify Yea or No-		- American Indien, White, etc.			
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WA			1 YES	:						
0										ACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Seconds (0-12) College (1-4 or 5+) DIETARY AIDE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										1		
										MED CEN		
										ODN		
BEC	MARK H. WAT	A	SWAN									
2	19e. INFORMANT'S NAME (Type/Print)		19b, M	AILING AOORE	SS (Street a	nd Number or Rural i	Route Number, Ci	ty or Town, State,	Zip Code)	5100		
-	ROBERT MORTIS	JR.	31	5 S.	SUNS	ET DR.	APT 2	WINS	ron S	ALAM.N.C.		
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 R	amoval from Stala	20b. PLACE AND	DATE OF DISP	OSITION (Na		OATE	20c. LOCATION				
	4 Donation 5 Other (Specify) BALTIMORE CEMETERY 12/9 BA:TIMORE, MD											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME											
	Murlyn	Crom	sitel	1	129	N. CAR	DLINE	ST. B	ALTO,	MD21213		
	23. PAHT Entar the diseases, a hock, or hear failur	or complications that a. List only one caus	caused tha death.	Do not ent	ar the mo	da of dying, suc	h aa cardiac d	or raapiratory	arreat,	Approximata interval Between		
	IMMEDIATE CAUSE (Final disease or condition ALDS											
	reaulting in death)	a										
		001 300	OR AS A CONSEQUE	ICE OF):						i		
5	Sequantially list conditions, if any, leading to immediate	bDUE TO (OR AS A CONSEQUEN	ICE OF):								
3	cause. Enter UNDERLYING CAUSE (Disease or injury	C										
CERTIFICATION	that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEQUEN	ICE OF):								
Ĭ I	readiting in daath) CAST	d								-		
J	PART ii. Othar algnificant condit	iona contributing to c	laath but not reau	iting in the	undariying	cause givan in	Part I. 24a.	WAS AN AUTOPS		WERE AUTOPSY FINDINGS		
A CA	Pneumo	nia						PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEL	Cytameleloir	us reti	mitis				_ '`	TES E NO		OF DEATH?		
	DID TOBACCO USE CON			YES 🗆	NO [UNCERTAIL	ND					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF	F DEATH (Chec	ck only one)							
2	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3 🗆 [OTH		5 🗆 Residence	6 Other (Spe	cify)				
	27. MANNER OF DEATH	26a, DATE OF II (Month, Day		b. TIME OF INJURY	2ac. INJI WO		28d. DESCRIB	E HOW INJURY	OCCURED			
	1 Natural 5 Pending 2 Accident Investigation			М		ES 2 NO						
3	3 Suicide 6 Could not 6	building, e	INJURY — At home, Ic. (Specify)	lerm, street, li	ectory, office		281. LOCATION City or Tow	(Street and Num m, State)	ber or Rural Ro	ute Number,		
<u> </u>	29a. CERTIFIER											
28. CERTIFIER 1 CERTIFIER 1 CERTIFIER 1 CERTIFIER 1 CERTIFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.												
3				nigition, in m	opinion, di							
	296, SHAMPUME AND TITLE OF CERTIF	House	OFFICER			D-4052		29d. D		Month, Day, Year)		
2	30. NAME AND ADCRESS OF PERSON NO.	WHO COMPLETEO CAUSE	OF OEATH (ITEM 27)	(Type, Print)		1	•		17/	1		
	DR. OCHAMES NOR	THWEST HO	EDULT LO	ENTE	DAND	ALLSTO W	am cu	21133				
	31. DATE FILED (Month, Day, Year)	# 32. BEGISTRAR	'S SIGNATURE	L-n	FC1 11 12	,,000, 000						
	DEC 0 9 1994	July Sauches	rhardall									



-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAN TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may remained by the attending physician and completely filled in by the funeral director, page 5 should be death to filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at angel. DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF	VIARYLAND / CE				EALTH DEAT		MENT	AL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DAT	E OF OEATH		./165	3. TIME OF DEATH
	Annie P. Jenkins		Proctor						Dec	ember 4		1994	м
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER		IF UNDER		7 DAT	E OE BIOTH		8. BIRTH Country	PLACE (State or Foreign
	220-18-5176	1 🗆 M 2 💢 F	68	YRS.	MONTHS	DAYS	HOURS	MIN.	MAF	th, Day, Year)	1926		vland
_	9e. FACILITY NAME (If not institution, give st	The second states of		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY							NTY OF O	EATH	
5	3817 Crestlyn Roa	ad			Ba	alti	more]	N/A	
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY, TOWH OR LOCATION								10d. INSIDE CITY	
8	MARYLAND	n/a		BALTIMORE									LIMITS?
A	10e. STREET AND NUMBER	AVENUE				101.	ZIP CODE				10g. CIT	HAT COUNTRY?	
띨	-001					21	218			STATES			
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried XX Widowed 4 Divorced	NT EVER IN U.S. ARI I YES 2 (1) WAR OR DATES	2 NO If yee, specify Cuben, Mexican, Puerto Rican, etc.)						Black	- American Indian, , White, etc. y: BLACK			
E	15. DECEOENT'S EDUC (Specify only highest grade	16e. OEC	EDENT'S	USUAL O	CCUPATIO	ON st of working		te	b. KIND OF BUS	INESS/IN	DUSTRY		
WELLETED	Elementery/Secondery (0-12)	life.	Do NOT u	se retired.)		SI OF WORKIN	g		n/a				
-	10 IH		" HOUSEWIFE n/a										
17. FATHER'S NAME (First, Middle, Last) WILLIAM L. JENKINS 18. MOTHER'S NAME (First, Middle, Malden Surname) MABLE WINN													
10	SHEILA TOLE	S	3817 CRESTLYN ROAD, BATTIMOE MARYLA								ND 21218		
	20e. METHOD OF DISPOSITION XIX Burlel 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify)	oval from State	20b. PLACEAND DATE OF DISPOSITION (Name of Commetery, Grematory or other place) NATIONAL CEMETERY 12 9 BALTIMORE, MARYLA									MARYLAND	
22. NAME AND AGORESS OF FACILITY March Funeral Home East 1101 E. North Avenue/Baltimore, MD 2													
	23. PART i. Enter the diseeses, or c shock, or heert feliure. I	omplications the	et caused the dea	ath. Do i	not enter	the mo	de of dyl	ng, euch	as ca	rdiec or respi	ratory ar	reat,	Approximata intervei Between
	IMMEDIATE CAUSE (Final disease or condition												Onset and Daeth
	disease or condition resulting in daeth) e. CSOD/REGCO/ CANCER OUE TO (ON AS A CONSEQUENCE OF):										3 Months		
	OUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CAI	cause. Entar UNDERLYING CAUSE (Disease or injury												
E	thet initiated events	DUE TO	(OR AS A CONSEO	UENCE O	F):								
H	resulting In death) LAST												
	PART ii. Dther aignificant condition	contributing to	deeth but not re	euiting	in the ur	nderiying	ceuse g	iven in	Pert i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
ICAL	cervical ca	NUEZ								PERFOR	./		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME										/	-	1	OF DEATH? 1 YES 2 NO
ä	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEAT	TH YE	S 🔲 I	NO 🗆	UNC	ERTAIN	1 🗆				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEA									
PHYSICIAN: MEDI	1 Tes 2 Dio	1 Inpatient 2	ER/Outpatient 3				5 🗆 Re	eldence	8 🗆 Oth	ner (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE Of (Month, E	Pay, Year)	28b, TIM INJ	E OF IURY	28c. INJU WOI	RK?		28d. DI	EŞCRIBE HOW IN	JURY OC	CURED	
B√	2 Accident Investigation	200 BLACE (OF INJURY — At hor		M		ES 2	NO					
TED	3 Suicide 8 Could not be 4 Homicide determined	building	etc. (Specify)	ne, reym,	mireet, rect	ory, omce	· 		C/t	CATION (Street a y or Town, State)	nd Numbe	or Rumal A	oute Number,
Significant Street and Number of Hurse determined 200. CERTIFUE 1 CERTIFUE 1 CERTIFUE 1 CERTIFUE 1 CERTIFUE 2 Control of the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner es stated. One) 201. COLGI TON (Street and Number of Hurse City or Town, State) 202. CERTIFUE 1 CERTIFUE PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner es stated. One) 203. CERTIFUE 1 CERTIFUE PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner es stated.										end menner ee stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER					1	29c. LICE						(Month, Day, Year)
BE	Edward Vin							4#		50		2-7	,
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAU	SE OF OEATH (ITEM	27) (Туре									
	Edward Kim 31. DATE FILED (MATTE Day, Year) 100 A	600 P	Mo He	SI	E	BaH	1 MOR	e	Mi) ZIZ	287	-	
31. DATE FILED 18 19 1994 32. REGISTRATE SIGNATURE PROJECT]			

DIVISION OF VITAL RECORDS P.O. BOX 68760

	_	FOR 1 - STATE REGISTRAR	1, 2/,	STATE OF	MARYLANI		RTMENT	OF H	IEALTH	AND TH	MENT	AL HYGIEN REG. NO			
		1. OECEDENT'S NAME (First, DONNA	, Middle, Last)	-				PUG	п		2. DAT DE	E OF DEATH	1 99		3. TIME OF DEATH 2:48 P
		4. SOCIAL SECURITY NUMBER	BER	Ruth 5. SEX	8. AGE (In yrs	last hirthday				R 24 HRS.		E OF BIRTH	133		
	9	216-84-096		1 M 2 F	2		MONTHS	DAYS	HOURS	MIN.	(Mo	nth, Day, Year)	067	Country)	
3 should		9a. FACILITY NAME (If not in					9b. CITY,	TOWN	DR LOCATI	ON OF D		ne 30,1	-	Mary TY OF DE	
	OR	902 ST.PA	UL SI	REET A	PT.1B		BA	LTI	MOR	E			AN THEM		
s 1, 2,	DIRECTOR	RESIDENCE OF DEC	10b. COUNT	v		T 40: 01	THE TOWN O								
Page	IR I	Maryland	1012 000111			Baltimore								IOd. INSIDE CITY LIMITS?	
ermit.		10e. STREET AND NUMBER				10f. ZIP CODE								I X YES 2 NO	
nsit p	ER/	3609 Keysto	one Av	enue						212					
FOUCEU ling physician. the burial-transit permit. Pages	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo			NT EVER IN U.S. 1 YES 2 WAR OR OATES	ARMEO NO	- 11	f yes, sp	ENDENT (ocify Cubic 2 X NO	n, Mexice	n, Puerte	IN? (Specify Yes o Rican, etc.)	or No—	14. RACE Black, Specify	- American Indian, White, atc.
r attend use as			EOENT'S EDU		18a.	DECEDENT'S USUAL OCCUPATION					16b. KIND OF BUSINESS/INOUSTRY				WHILE
\$ 5 V	COMPLETED	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT I	ive kind of work done during most of working . Do NOT use retired.) Housewife								
e de fa	OS	17. FATHER'S NAME (First, M.	liddle, Last)						18. MOT	HER'S NA	ME (First	, Middle, Maiden	Surname)		
ed by uid be	8			nown	-	Ruth Nunnally									
retained 1 5 should notified	유	190. INFORMANT'S NAME (7)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Friarswood Ct. #101 Belcamp, Maryland 2101									and 21017
y be		20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State													
e 6 ma ector, p		1 X Buriel 2 Cremetio 4 Donation 5 Dother		oval from Stata	cemetery.	cremetory or	other plecel			مأح	1	12/94 S			
		21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE	(o	- VIEW	22. N	NAME AN	ID ADDRE	SS OF FA	CILITY	12/194 5	ykest	/1116	, rid.
		166	llan	Soit	- ()							ıneral Balt			21211
executed within 24 hours after and completely filled in by to boulal, cremation, or remandle event, the medici	CATION	IMMEDIATE CAUSE (Findiseese or condition resulting in deeth) Sequentielly list condition in any, leeding to immediately it any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding to immediately in any, leeding the angle in any leeding the any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the angle in any leeding the any leeding the angle in any leeding the a	ions, diete	s. ACUTE NADUE TO	u'se on eech i	INTOXIC	ATION OF):	the mo	de of dy	ing, suc	h ee ce	rdiec or reepi	iratory sm	ost,	Approximete interval Between Onaet and Death
th certificat ending phy I Hygiene p or other	CERTIFICA	ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): d													
requires that the doesn signed by the of Health and Meshows any Injur	MEDICAL	PART II. Other significe										24a. WAS AN PERFOR	RMED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
e law has b Dept.	SICIAN:	DID TOBACCO U		RIBUTE TO CA		LACE OF DEA			UNC	ERTAII	ИП				
NY: The ficate has State D	SICI	EXAMINER? 1 □XVES 2 □ NO	_	HOSPITAL:	-		OTHER	11		aldenne		or (Specific)			
YSICIA S certif th the	РНҮ	27. MANNER OF DEATH		28e. OATE OF	FINJURY	FUU N	E OE-	28c. INJI WO	URY AT	Parotinua		ESCRIBE HOW I			FRIEND
NG PHYS fler this ceath with marked	ВУГ		Pending Investigation	FOUND 1		2:00		1 🗌 Y		XNO.	UNKN	OWN			
ATTENDIN ECTOR: At rs after de n 28 ls r	Œ		Could not be determined	28e. PLACE (building,	OF INJURY — At, atc. (Specify)	home, farm, OUND IN					28t. LO Cit				Number ST. APT. 1B
로 글 전 ==	COMPLE			CIAN: To the best of s											and manner se stated.
TO THE HOSPI TO THE FUNER be filed within	ш	29b. SIGNATURE AND TITLE	OF CERTIFIE	1 1 80	,				29c, LICI	ENSE NU	ABER		29d. DATE	SIGNED (Aonth, Day, Year)
t the state of the	ТОВ	De	ww	166	sate n	D			0	.C.N	1.E.		▶ DE	C.08	3,1994
		30. NAME AND AODRESS OF			11	1 Pe		tre	et,	Ba]	ltin	nore,	Mary	land	1 21201
(4)		DEC 0 9 19	194 7	32 REGISTRA	or hardel	į.									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27, PER MEO FILM G-718 12/30/94 t.t

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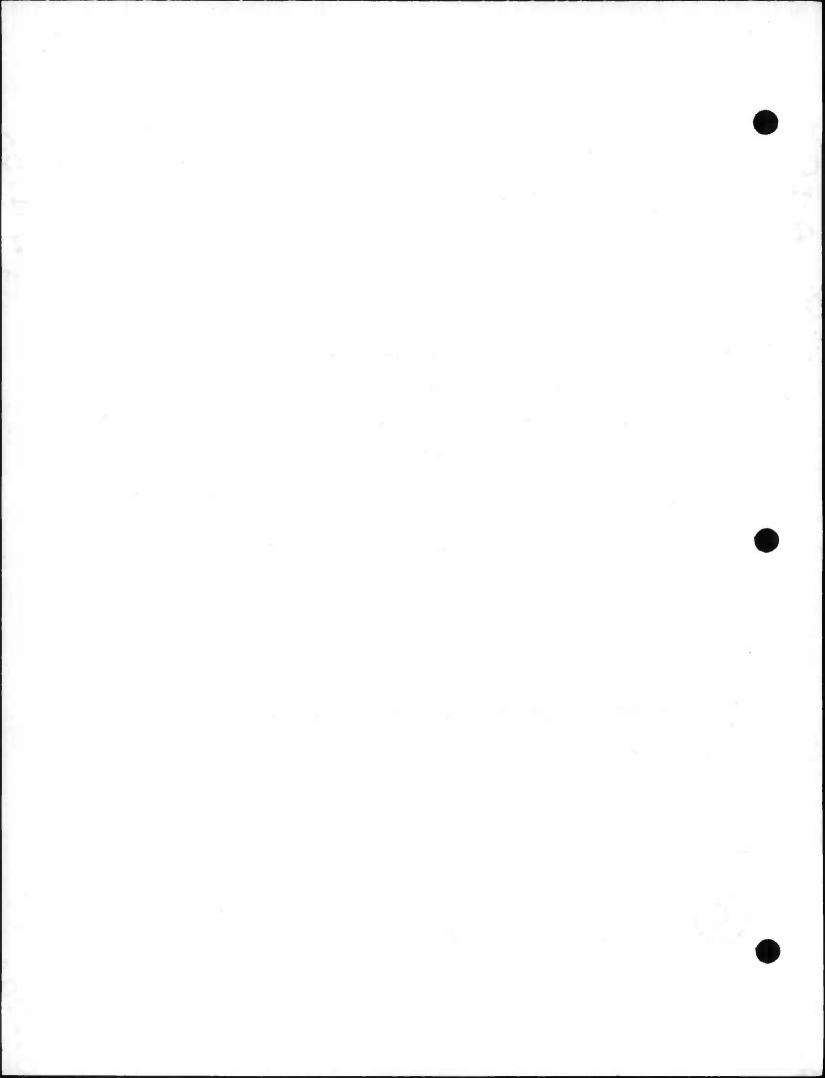
	1 - STATE REGISTRAR	SIMIE UP IV		RTIF	ICATI	E OF	DEAT	H H	MENIA	REG. NO			
	1. DECEOENT'S NAME (First, Middle, Last)				**				2. DATE	OF DEATH		VEAD	3. TIME OF OEATH
		AMONT	RIC	CHAF	RDSO	N			DEC	Ö	3 19	994	9:33 A m
1		S. SEX	6. AGE (In yrs. last i		IF UNDER	QAYS	IF UNDER	24 HRS.	7. DATE	OF BIRTH	1001	Countr	PLACE (State or Foreign
	117	XX M 2 🗆 F		YRS.	3	2				T.1,	_	MARY	
œ	9s. FACILITY NAME (If not institution, give street						R LOCATIO	ON OF DE	ATH		9c. COL	JNTY OF D	EATH
DIRECTOR	JOHNS HOPKINS H	<u>OSPITA</u>	L		BAL	TIM	ORE				<u></u>	n/a	
REC	10s. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY
	MARYLAND n/	a		BALTIMORE									1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101	ZIP CODE						THAT COUNTRY?
N.		ENUE	T 51/50 11/10 10/10	-	T		212	-			UNIT		STATES
BY	1 X Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARM YES 2 NO RR OR DATES)		If you, spe	ENOENT O Icify Cubsi 2 X NO	1, Mexicar	n. Puerto I	? (Specify Ys: Rican, etc.)	s or No-		- American Indian, White, stc. BLACK
COMPLETED	15. OECEDENT'S EDUCAT (Specify only highest grade con		(Ghr	a kind of s	work rione	CCUPATIO	N st of workin		16b.	KIND OF BU	SINESS/IN	DUSTRY	
9	,	College (1-4 or 5+) life, L	DO NOT U	se retired.)		, o. wo.lu.			,			
M	n/a 17. FATHER'S NAME (First, Middle, Last)		B	ABY						n/a			
8	ANTHONY RICHAL	RDSON					18. MOTH	LOVE		Aiddle, Maiden QUEEI			
0	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	S (Street s	nd Number			per, City or Tow		D Code)	
LOVETA QUEEN 2015 MC KEAN AVENUE, BALTIMORE, MD 21217									21217				
	20s. METHOD OF DISPOSITION 1XXBurled 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION (Name of Computer of Compu												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH1101 E. NORTH AVENUE												
	1 ture the	han		-	V	M. C	. MA	RCH	FH	1101	E. 1	NORTH	AVENUE
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line.										rest,	Approximeta		
	iMMEDIATE CAUSE (Fine) disease or condition resulting in death) SUDDEN INFANT DEATH SYNDROME WITH EARLY BRONCHIOLITIS											Interval Between Onset and Death	
	ESWI SE	DUE TO	(DR AS A CONSEOU	JENCE DI	F):		43		515				
ON	Sequentially list conditions, b	DUE TO	(OR AS A CONSEQU	IENCE O	F)·	-							
AT	if any, leading to immediate cause. Enter UNDERLYING												į
Ĕ	CAUSE (Diseese or Injury that initiated evente	DUE TO (OR AS A CONSEQU	JENCE OF	F):								
CERTIFICATION	resulting in death) LAST												
	PART II. Other aignificent conditions c	ontributing to	daeth but not ree	euiting	in tha ur	nderiying	ceuse g	ivan in I	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_	1			OF DEATH? 1 YES 2 NO
ž	DID TOBACCO USE CONTRIB	UTE TO CA	USE OF DEATI	H YE	S 🔲 I	NO 🗆	UNC	ERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE	OF DEAT									
YSI	1-7 YES 2 □ NO 1		ER/Outpetient 3 f	DOA	4 Nun		5 🗆 Res	idencs (B 🗆 Other	(Specify)			
	27. MANNER OF DEATH 1 XXNetural 5 Pending	28s. DATE OF (Month, De		28b. TIM INJ	E OF URY	28c. INJU WOI	RK?		28d. DES	CRIBE HOW I	NJURY OC	CURED	-
2 Accident 3 Suicide 4 Homicide 28s. PLACE OF INJURY — At home, farm, streef, factory, office 4 Homicide 28s. PLACE OF INJURY — At home, farm, streef, factory, office 4 Homicide 28s. PLACE OF INJURY — At home, farm, streef, factory, office 4 City or Town, State) 28s. PLACE OF INJURY — At home, farm, streef, factory, office 4 City or Town, State) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and piace, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the best of exemination and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and manner as stated.													
									oute Number,				
29s. CERTIFIER (Check only one) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, dats and piace, and due to the cause(s) and manner as stated.													
S I	2 X MEDICAL EXAMINER: C	In the besis of ex	emination and/or inv	restigatio	n, in my o	pinion, de	eth occur	d at the t	time, dats	and place, an	d due to ti	he ceuse(s)	snd manner es stated.
H H	296. SIGNATURE AND TITLE OF CERTIFIER	(1)	At				29c. LICE						(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CALL	OF DEATH OTTO	27) (%-	Daire		0.	C.M	.E.		₽ D)	EC.U	4,1994
	MARIO F. GOLLE	JR M	2 111 F			ree	t, E	Balt	imo	re, M	lary.	land	21201
DECU 9 1994 Julia de en en en en en en en en en en en en en													



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or atter	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as		
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JR AT	IRECT	ours a	em 2
TAL O	AL D	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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		FOR 1 _ STATE	STATE OF I	MARYLAND /	DEPAR	RTMENT OF I	HEALTH AND	MENTAL HY	YGIEN	E		
		REGISTRAR				ICATE OF			G. NO.	5		
ı	- 4	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DI				3. TIME OF DEATH
1	14	Sylvia		Rai	ıdve	re		Dec.	7	199	YEAR	2:45 A M
ł		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1 YEAR	IF UNDER 24 HRS.	T DATE OF DE	-		8. BIRTH	IPLACE (State or Foreign
	-	122-28-3209	1 🗆 M 2 📈 F	69	YRS.	MONTHS DAYS	HOURS MIN.	Feb. 3	,192	25	Counti	Russia
1	~	9a: FACILITY NAME (If not institution, give st	treet and number)			96. CITY, TOWN	OR LOCATION OF DE	EATH		9c. COU	INTY OF D	EATH
١	DIRECTOR	Maryland General	<u>Hospita</u>	1		Baltin	more City	/				
ı	H.	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LOCA	TION		-			10d, INSIDE CITY LIMITS?
ı		Maryland Balti	more		La	insdowne						1 TES 2 NO
	FUNERAL	2941 Freeway				10	1. ZIP COOE 21227				J.S.A	WHAT COUNTRY?
	5	tt. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR		13. WAS DEC	CENDENT OF HISPAN	NIC ORIGIN? (Sp	ecify Yes	or No-	14. RACE	E — American Indian, k, White, etc.
	B	t Never Merried 2 Married 3XX Wildowed 4 Divorced	IF YES, GIVE V			t TYES	ecify Cuban, Maxica 2 NO Specif	y:	atc.)		Speci	
	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		18a. DE	CEDENT'S	USUAL OCCUPATE work done during mo	ON .	16b. KIND	OF BUS	SINESS/IN	DUSTRY	
ı	<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT u	se retired.)						
	N N	Unknown		Ma	achir	ne Opera	tor					
	8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA		Meiden	Sumame)		
	BE	Unknown		Pet			Unkno					known
	0	19a. INFORMANT'S NAME (Type/Print)		19			and Number or Rural i					
	-	Arthur L. Drager,			5 Li	ight Str	eet Suit	te 510	Ba	ltimo	ore,	Md. 21202
		20a METHOD OF OISPOSITION 1 Burlal 2 Cremation 3 Rame	oval from State	20b.PLACE : cemetepy, cre	AND DATE	OF DISPOSITION (Nather place)		OATE				
		4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG	CHOCE	- Pai	rkwoc	od Cem.	12-	-9-94	Ва	ltimo	ore,	Md.
		21. SIGNATURE OF PUNERAL SERVICE LIC	1				ND ADORESS OF FA			-		
		taul Z Hart	IntoK.			Leona	ard J. Ru	uck,Inc		5305	Harf	ford Rd.
ſ		23. PART I. Enter the disesses, or c shock, or heart fallura.	omplications the	t ceused the de	ath. Do	not enter the mo	ode of dying, suc	h sa cerdiec c	or reapi	ratory ar	rest,	Approximate
ı		IMMEDIATE CAUSE (Final	List Only Ona Cat	ise on each lina	1.							interval Between Onset and Death
		diseese or condition resulting in death)	S	tage 1	v Bı	ceast C	ancer w	ith M	eta	stsi	S	unknown
		Tooling in again,		(OR AS A CONSE						Bone		differiown
	Z	rwesterous actually contact to a	0							20116	-	
ı	CERTIFICATION	Sequentisity list conditions, If sny, leading to immediate	DUE TO	(OR AS A CONSE	DUENCE O	F):						
	2	cause, Enter UNDERLYING CAUSE (Disease or injury	2									
	1	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	P):						
	E		i									
		PART II. Other algnificant condition	s contributing to	death but not r	reaulting	In the underlyin	g cause given in	Part I. 24a.	WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS
·	2								PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
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ı	Σ	DID TOBACCO USE C	ONTRIBUTE	TO CAUS	F OF	DEATH Y	ES NO					1 TES 2 NO
ı	AN	25. WAS CASE REFERRED TO MEDICAL			-		LACE OF DEATH (Ch		_			
	S	EXAMINER? 1 YES 2 XNO	HOSPITAL:	ED/Out-off to 0		OTHER:						
	PHYSICIAN: MEDICAL	27. MANNER OF DEATH	1X Inpatient 2 28a. DATE OF		285. TIN		10 5 Realdence	8 U Other (Spe- 28d, DESCRIBI		WILLIAM OC	~ InEn	
		1 Netural 5 Pending	(Month, D		IN.	JURY WO	YES 2 NO	200. DESCRIO	c now n	NJONT OC	CONED	
	BY	2 Accident Investigation 3 Suicide 8 Could not be	28a, PLACE O	F INJURY — At ho	me ferm	street, factory, offic	_	28f. LOCATION	/Ctmat a	and Mromba	r or Dumi I	Boute Number
		4 Homicide B Could not be	building,	etc. (Specify)		,,		City or Tow	rn, State)	ind reambe	V OF FIGURES F	toda Namba,
	E	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the heat of	on knowledge de		and and after all and a district	1=15a=7a181		o. 45	DN 52	211	
	COMPLETED	(Check only one) 2 MEDICAL EXAMINE										and manner as stated.
		296. SIGNATURE AND TITLE OF CERTURIES		 -			29c. LICENSE NUM		., .,			
	O BE	The state of the s	9	M-1	2		89230	MOCH		Z9a. DAT		(Month, Day, Year) -7, 1994
+	7	Ruby Jean To	completed cause ochio,	M.D. C	M 27) (Type	Marylan	nd Gene	ral Ho	spi	ital		
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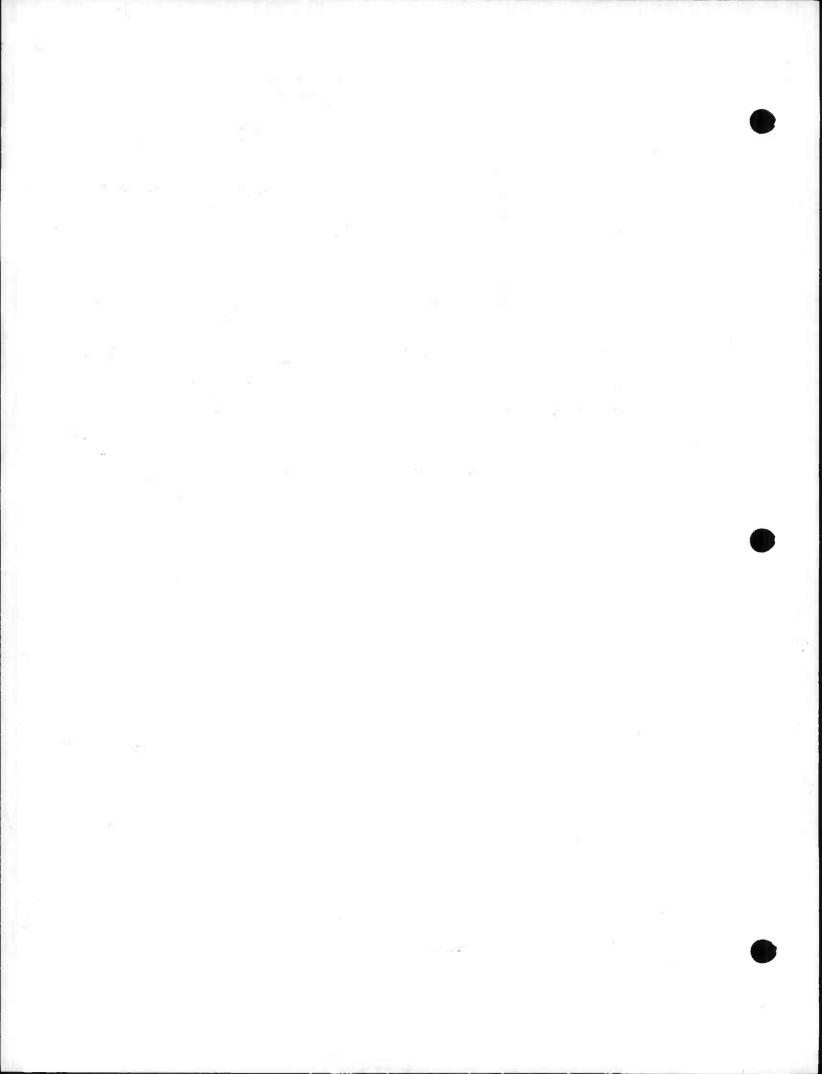
21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with chours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		C	INITI	CALE	Jr DEP	AI PI	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	ELMER	LEROY	RICK	ERDS			2. DATE OF MONTH	DA	94	YEAR	3. TIME OF DEATH 3:25 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 8.	AGE (In yrs. las	t hirthday)	IF UNDER 1 YE	All JE IMP	ER 24 HRS.	7. DATE OF		7.5	a BIOTH	IPLACE (State or Foreign
	219-10-1220	1 X M 2 🗆 F	59	YRS.		YS HOURS		Oct.	ny, Ybar)	925	Countr	
	9e. FACILITY NAME (If not institution, give at				9b. CITY, TO	WN OR LOCA	TION OF DE	ATH		9c. COU	NTY OF D	EATH
TOR	4453 Fenor Ro	1., 212	27		Balt	imore	High1	ands		Bal	ltimo	ore
ñ l	10e. STATE 10b. COUNTY			10c. CITY	, TOWN OR L	OCATION						10d. INSIDE CITY
PIR	Maryland Balti	more		Bal	timor			5				LIMITS?
FUNERAL DIRECTOR	100. STREET AND NUMBER 4453 Fenor R	ld.,				10f. ZIP CO	^{0€} 21227	7		10g. CITI	USA	VHAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AR	MED				IC ORIGIN? (S		or No —	14. RACE	E — Americen Indian, t, White, etc.
B	1 Never Merried 2 XX Merried 3 Wildowed 4 Divorced	FORCES? 1 X IF YES, GIVE WAR WW 2	or dates Navy			YES 2 XN		n, Puerto Rica	n, atc.)		Speci	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		(G	ive kind of w	USUAL OCCU	PATION g most of work	king	16b. KII	ND OF BUS	INESS/INE	DUSTRY	
PLE	Elementary/Secondary (0-12) 12th Grade	College (1-4 or 5+)		od In	specto	or		Bal	timor	re Ci	itv F	lealth Dept.
8	17. FATHER'S NAME (First, Middle, Lest)			-	0,000		THER'S NAS	ME (First, Midd			0, 1	icaron bept.
BE C	Edward L	Ricl	kerds					nt			Frye	
TO B	190. INFORMANT'S NAME (Typo/Print) Mrs. Doris M. Ri	ckerds	191	4453	Feno	Rd.,	or Aural A Balt	imore	City or Town	, State, Zip 21	227	
	20e. METHOD OF DISPOSITION 1 X Burley 2 Cremetion 3 Remo	oval from State	20b. PLACE A	ND DATE C	of DISPOSITIO	N (Neme of		DATE			City or To	
	4 Donetion 5 Other (Specify)		<u> Cedai</u>	<u>^ Hil</u>	her place) Ceme	etery	12/6	5/94	Balt	imor	e. M	Maryland
	21, SIGNATURE OF FUNERAL SERVICE LIC	Kevin	E. Ec	ker	Mc		Funer	al Hm				
	23. PART I. Enter the diseases, or o	complications that or	used the de	ath Do n	23	P P	ataps	co Av	e	Balto	<u> </u>	
	shock, or heart failure.	List only one cause N YOCA DUE TO (OR	on each ilna				lying, such	1 SS Cardiac	or respii	etory an	rest,	Approximate interval Between Onset and Death
İ	resulting in death)	Hyperte	AS A CONSEC	DUENCE OF	7: 1	,		7		_		
NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSE	DUENCE OF	arolo	Vasc	ular	DIS	case	2		
ICA	cause. Enter UNDERLYING CAUSE (Disease or Injury	. Bronch	AS A CONSE	15th	ma.							
CERTIFICATION	that initiated events resulting in desth) LAST	d	AS A CONSEC	OENCE OF):							
	PACT is Other significant condition	a contributing to do	nah hua maa i		- 4b - 1 - 4	4.121.2.22		otte. I	Unio Co			
EDICAL	PART li. Other significant condition	a contributing to de	stn but not r	eauiting i	n the under	lying cause	given in i	Part I. 24	PERFOR		24b.	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
								_ 1	☐ YES 2	□ NO		OF DEATH?
N	DID TOBACCO USE C	ONTRIBUTE T	O CAUS	E OF	DEATH	YES [7 NO					1 YES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL					6. PLACE OF		ck only one)				
S	EXAMINER? 1 YES 2 NO	HOSPITAL:	I/Outpatient 3	□ DOA	OTHER:	Home 5 🗆 1	Residence	6 Other (S	pecify) F	7201	P _	
PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJ (Month, Day,)		28b. TIMI INJ	E OF 280 URY	: INJURY AT WORK?		28d. DESCR		JURY OC	CURED	
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF IN building, etc.	JURY — At ho (Specify)	me, farm, a				28t. LOCATIO	ON (Street e	nd Number	r or Rural F	Route Number,
Ë,	4 Homicide datermined											
COMPLETED	(Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE	CIAN: To the best of my R: On the basis of exem										e) end menner es stated,
H	296. SIGNATURE AND TITLE OF CERTIFIER	D				29c. LI	CENSE NUM	(02_		29d. DAT	2/5	(Month, Own Year)
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	OF DEATH (ITE	M 27) (Type,	Print)	OM<	46	Rai	hm	OVP	M	021229
0	31. DATE FILED (Month, Day, Year) DEC 0 9 1994	32. REGISTRAR'S	SIGNATURE		VVII	VII.2 /	IV		-1 VI	1		
	DEC 0 9 1994 Ju	in diwater	ardall									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPIT TO THE FUNE De fied within

		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	IEALTH AND	MENTAL HYGIEN		
2		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AU VE	3. TIME OF DEATH
		Edna	Clay	Ri	ghter		Dec. 7,	1994	12:25 p M
		4. SOCIAL SECURITY NUMBER		in yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0. B	BIRTHPLACE (State or Foreign Country)
Pin		220-46-5714	1 □ M 2 💢 F 10	1 YRS.			Oct 28, 18	893 M	laryland
3 should	<u>~</u>	9e. FACILITY NAME (If not institution, give s				OR LOCATION OF DE	EATH	9c. COUNTY	
1, 2,	유	Golden Age Guest	Home		Woodb	ine		Carro	11 County
ages	DIRECTOR	10a. STATE 10b. COUNTY	,	10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?
physician. burlal-transit permit. Pages 1, 2,			11 County	Wo	odbine				1 YES 2 NO
it per	FUNERAL	10a. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
cian. -trans	ᄬ	1442 Buckhorn R	12. WAS DECEDENT EVER IN	III S ADMED	12 340 050	21797		USA	
ohysic		1 Never Merried 2 Merried	FORCES? 1 YES	2 X NO	If yes, sp	ecify Cuben, Mexica	NC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc.
attending physician se as the burial-tra	ВУ	3 🔀 Widowed 4 🗌 Olvorced	I FES, GIVE WAY, ON DA	WES .	I TES	2 X NO Specif	γ:		Spec <i>Hy:</i> White
	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPATION	ON ast of working	16b. KIND OF BUS	SINESS/INDUSTI	RY
fal or u	삗	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)				
the hospital detached for once.		8th Grade 17. FATHER'S NAME (First, Middle, Last)		Homema	aker			Home	
be de		John Isaac Holbr	ook				ME (First, Middle, Maiden enora Ritte		
5 should I	B	19e. INFORMANT'S NAME (Type/Print)	OOR	19b. MAILING	ADDRESS (Street e		Route Number, City or Tow.		
5 C	유	Mrs. Marie Loper					allstown, l		.133
may be or, page		20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OF DISPOSITION (Na	me of		CATION — City	
ge 6 may frector, p		4 Donation 5 Other (Specify)	Mt	• Paran	Cemetery	У	12-10 Ra	ndalls	town, MD
death. Page tuneral direct		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		Loring	BVers I	GLUTY Funeral Din	rectors	Inc
after death. Page 6 may be by the funeral director, page moval.		John K &	tyneled or				Rd. Randal		
ours after d in by the or removal		23. PART I. Enter the diseases, or o	omplications that causad List only one cause on ea	the deeth. Do	not anter the mo	de of dying, suc	h as cardlec or respl	Iratory arrest,	Approximata
A nours illed in the in, or rer		IMMEDIATE CAUSE (Final	/// /		1.				Intarval Between Onset and Daath
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8 9 - 0			DUE TO (QA AS A	CONSEQUENCE O	Disease	Boto			
and and buy	CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE O	n:	peer			
sician prior t	CAT	If any, leeding to immediate cause. Enter UNDERLYING	Freu	ala	V				į į
n certifical ending phy Hygiene I	Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				
he death certificate be the attending physician Mental Hygiene prior to hiury, or other traur	EBI	resulting in deeth) LAST	L						
that the death certificate bed by the attending physicith and Mental Hygiene pri any Injury, or other tr	AL C	PART II. Other significant condition	s contributing to deeth be	ut not resulting	In the underlying	g ceuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS
	S						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
requires the een signed of Health a	MEDIC							(B) NO	OF DEATH?
has been Dept. of 1	ä	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	F DEATH YE	S NO E	UNCERTAIL	<u> </u>		
N: The lav ficate has State Dep item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:				
ICIAN: sertifica the St	YSI	1 TYES 2 TO NO	1 - Inpatient 2 - ER/Outpa		4 Nursing Hom	e 5 🗆 Rasidence	6 Other (Specify)		
PHYSICIAN: The PHYSICIAN P	F	27. MANNED OF DEATH 1 D Natural 5 Pending	(Month, Day, Yeer)	28b, TIM IN,	URY WO	RK?	28d. DESCRIBE HOW II	NJURY OCCURE	D
After the state of	B	2 Accident Investigation	28e. PLACE OF INJURY	— At home term		ES 2 NO	201 LOCATION (Committee		10
ATTENDING PHYSICIAN: The law requires that the this certificate has been signed by the certificate has been signed by the thin the State Dept. of Health an the marked, or item 23 shows any	6	4 Homicide 6 Could not be	building, etc. (Speci	ify)	on out, ractory, orner		28t. LOCATION (Street a City or Town, State)	Ind Number of Hi	rer House Number,
E S II		290. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the beat of my knowle	adae deeth conum	ad at the time date				
1 0 m	СОМР		R: On the beals of examination						use(e) and menner as stated.
THE HOSP THE FUNE filed within	ш О	29b. SIGNATURE AND TITLE OF CERTIFIES				29c4LICENSE NUI			NES (Month_Dey, Year)
TO THE HOSP TO THE FUNE be filed within	00	Patteck Tu	wednes			D2080	76	▶ /2	17/84
	유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type		(D1	-(1)	1	. 0 2:5:
6		THURICK LUR	NOS, MI)	1425	Liber	ty Kd.	Elder	luy	MD 5158
5		DEC 0 9 1994	32. REGISTRAR'S SIGNA	TURE		/		1	
		DEC 0 9 1994	up a water ren	704					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPIN OR ATTERNOOP PHYSICIAN: The law requires that the death certificate be executed within the float. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL Ment this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	REGISTRAR		CL	THIL	ICATE O	PUCAIN		REG.	10.			
	1. OECEDENT'S NAME (First, Middle, Last)						2	DATE OF DEATH			3. TIME OF DEATH	1
	Willie Rush						Ī	Dec (DAY 1	94	10:12	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEA	R IF UNDER 24 H	_	DATE OF BIRTH		8. BIRTI	HPLACE (Slate or For	
	248-10-1703	1 🔀 M 2 🗆 F	79	YRS.	MONTHS DAY	HOURS M	IN.	Apr 1	1 15	SO111	m Ch Caroli	ทล
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOW	N OR LOCATION (UNTY OF E		. IICI
DIRECTOR	Sinai Hospital]	Baltio	ore	City				
띭	10e. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN OR LO	CATION					10d. INSIDE CITY	
2	Maryland				Bal	timore	e Ci	itv			LIMITS?	10
AL	10e. STREET AND NUMBER					10f. ZIP CODE			10g. Cl	TIZEN OF	WHAT COUNTRY?	
FUNERAL	5731 Denwood Av	venue				21	206	5		US.	A	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	MED	13. WAS (ECENDENT OF H	SPANIC	ORIGIN? (Specify	Yee or No-	14. RAC	E — American India	i,
B	1 Never Merried 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W		0		specify Cuben, M ES 2X XNO S		uerto Ricen, etc.)		Spec	k, White, etc. ://y: Black	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION	18e. DEC	EDENT'S	USUAL OCCUPA	TION		16b. KIND OF	BUSINESS/IN	DUSTRY	DIACK	_
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	ve kind of v Do NOT us	work done during se retired.)	most of working						
AP.	5th			Ma	intena	ince			Hosp	ita	1	
Ö	17. FATHER'S NAME (First, Middle, Last)				-	18. MOTHER	S NAME	(First, Middle, Mail	len Sumeme)			
BE (Dublin Rush					Ide:	lla	Green				
0	190. INFORMANT'S NAME (Type/Print)					et and Number or F			Town, State, Z	ip Code)		
-	Marlene Spruie	1	5	731	Denwo	od Ave	2.	Balto	., MI	21	206	
	20a. METHOD OF DISPOSITION XXBuriel 2 ☐ Cremation 3 ☐ Rem	oval from State	compteny crar	natory or or	OF DISPOSITION				LOCATION -	•		
	4 Donetion 5 Other (Specify)		King M	lemor	rial Pa			6/94 Ra	ndallst	own,	m MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	- 01	7	22. NAME	ty Fur	F FACILI	TY 1 Hom	0			
	1 WE+	10W-	ece	5 3		8 W. N				1 to	, MD 21	201
- 1	23. PART I. Enter the diseases, or o	complications that	caused the dec	th. Do r	not enter the	node ot dying,	such s	s cerdiac or re	spiratory a	rrest,	Approxims	
	shock, or heart fellure. IMMEDIATE CAUSE (Final	List only one caus	sa on each lins.								Interval Ba	
	disease or condition resulting in death)	mvo	cardial	lin	farct	ion						
	recenting in death)		OR AS A CONSEC									
Z	Composition that are distant	hypo	oxemia									
CERTIFICATION	Sequentially list conditions, if any, isading to immediate	DUE TO (OR AS A CONSED	UENCE OF	F):							
2	cause. Enter UNDERLYING CAUSE (Disease or Injury		umonia									
	that initiated avents resulting in death) LAST	DUE TO (OR AS A CONSEO	UENCE OF	F):							
E	Totaling in ductily artor	,										
#		d										
IL CE	PART II. Other significant condition	d	dasth but not re	sulting i	In the underly	Ing causa giva	n In Pai	rt I. 24a, WAS	AN AUTOPSY	246	. WERE AUTOPSY FIN	DINGS
ICAL CE		d.	dasth but not re	sulting (In the underly	ing csuas giva	n in Pai	PER	ORMED?	246	O. WERE AUTOPSY FIN AWAILABLE PRIOR T COMPLETION OF CA	0
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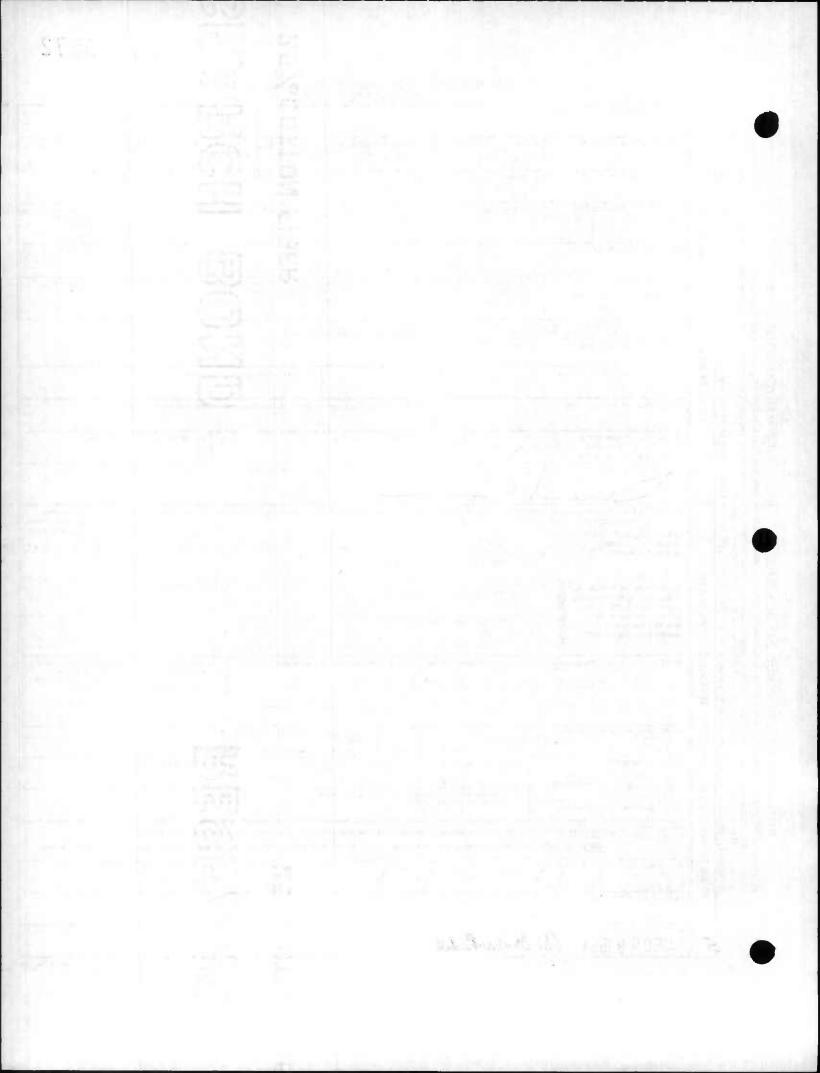
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Four after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

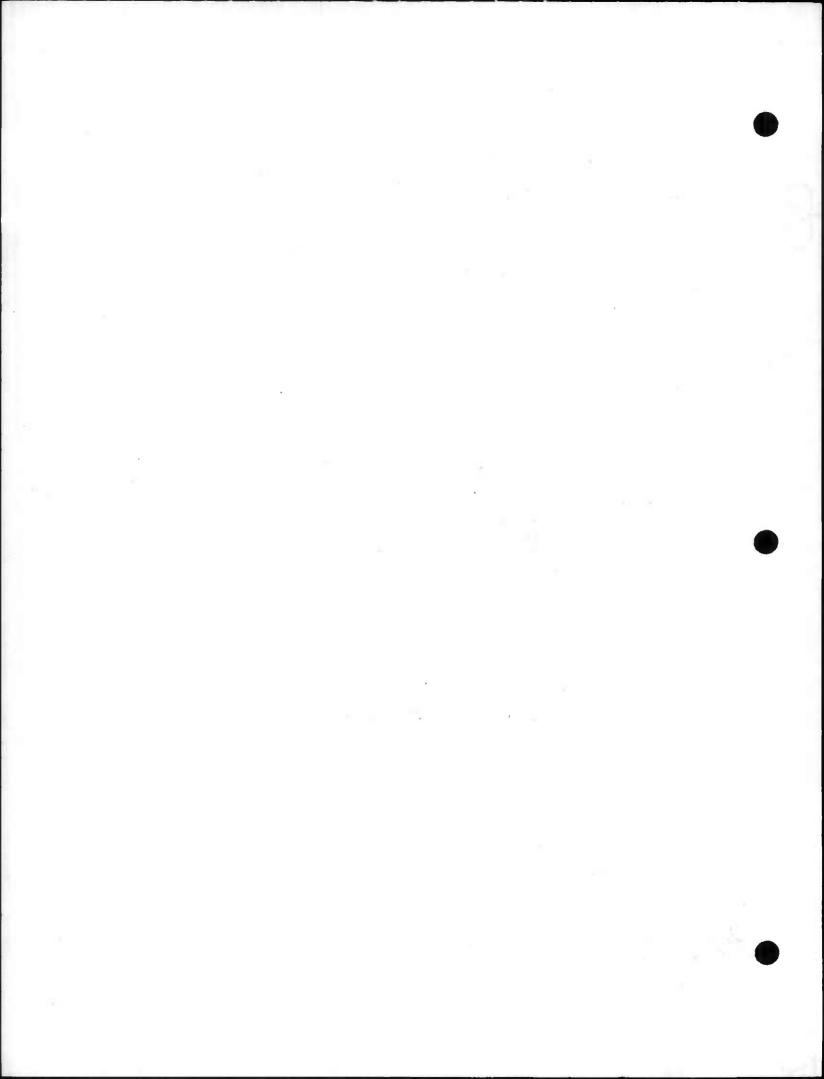
	1. DECEDENT'S NAME (First, Mid		- L la							MONTH	DAY		YEAR	3. TIME OF DEATH	
	Gladys		1 CN 8. SEX	8 AOE /	(In yrs. last birthda	al le mune	ER 1 YEAR	T er inner	R 24 HRS.	12		4-	94	IPLACE (State or Foreig	
			1 🗆 M 2 XF	88	YRS.	MONTHE		HOURS	MIN.	(Month, L	-190	6	Countr	(Y)	
	220-34-7330 se. FACILITY NAME (If not inetitus			00		-	ry, TOWN (2010017	1011 05 01		-190		UNTY OF D	th Carol	
œ	2302 Guilfo		,				Balt			EAIH		90. COU	UNIT OF D	EAIH	
DIRECTOR	RESIDENCE OF DECED		Avenue				Dali	TIMO	re						
E I	10e. STATE 100	b. COUNT	Υ		10c. C	ITY, TOWN	OR LOCAT	rign						10d. INSIDE CITY LIMITS?	
5	Md.					Balt	imor	ce						XX YES 2 NO	
A	10s. STREET AND NUMBER						101	. ZIP COL	E	-		10g. CIT	TIZEN OF V	WHAT COUNTRY?	
E	2302 Guilfo	ord .	Avenue				1	2121	8				USA		
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN	N U.S. ARMED	13	. WAS DEC	ENDENT	GF HISPAI	NIC ORIGIN?	Specify Yee		14. RACE	E — American Indian,	
8	1 Never Married 2 Mer		FGRCES? 1				1 YES	WIND	an, Maxica Specifi	in, Puerto Ric y:	en, etc.)		Speci	k, White, atc.	
														Black	
COMPLETED	18. DECEDE (Specify only hig	ENT'S EDU ghost grade	CATIGN completed)		16a. DECEDENT	of work done	e during mo	GN ast of work	ing	16b. K	IND OF BUS	INESS/IN	IDUSTRY		
ا ۲	Elementary/Secondary (0-12) 9 th)	College (1-4 or 5	+)		use retired.				100					
È					DOIL	esti	C	_							
_	17. FATHER'S NAME (First, Middle Peter Corle									ME (First, Mid		Sumame)			
20	19a, INFORMANT'S NAME (Type)	*			400	10 15			_	y Bro					
2										Route Number, Bal				1218	
	Gladys Gard			1 000				-	Ave						
	20a METHOD OF DISPOSITION 2 Burlel 2 Cremation	3 🗆 Rem	oval fram State	gem	PLACE AND DAT	r other place	e)	sme of	10	DATE O 4	20c. LOC	ATION -	- City or To	Maryland	
	4 Donation 8 Other (Spi		Bugge /	AI	Loutus	Men	OLT	L L	12-	09-94	TALD	ucu	S, I	daryland	
		4	101	/		21. SIGNATURE OF FUNERAL SERVICE LASHSEE 22. NAME AND ADDRESS OF FACILITY Derrick C. Jo									
	4611 Park Heights Ave. Balto., Md														
	23. PART I. Enter the disease or condition resulting in death)	t failure.	a. A Cu	use do a	ach ilna.	not ante	er the mo	eds of d	ying, suc	th as cerdia	c or respir	ratory ar		Approximate Interval Betwo	
IFICALION	shook, or hearl IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	t failure.	a. Due to	GRASA TEMO	ach ilna.	OP:	er the mo	eds of d	ying, suc	th as cerdia	c or respir	ratory ar		Approximata Interval Betw Onset and D	
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31. DATE FILED (Month, Day, Year)
DEC 0 9 1994

		1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF H		MENTAL HYGIENE REG. NO.				
		OECEOENT'S NAME (First, Middle, Last)	11.71.	- /	1		2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF DEATN		
			Walhan	V. 20	inders	5	12 08	3 94	7:15 AM		
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	iE (In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRT Coun	NPLACE (State or Foreign try)		
P		26-52-4/85	7	45 YRS.			1-25-	49	MID		
plnous	Œ	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF D	EATN	9c. COUNTY OF	DEATN		
2,3	CTO	30 South FULTON AVE BALTIMORE									
Pages 1,	I III	10a. STATE 10b. COUNTY	1	10c. CIT	TY, TOWN OR LOCA	TION			10d. INSIDE CITY		
- Pa	DIR										
permit.	AL	10a. STREET AND NUMBER			10	1. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
TS.	E E	50 South	ZINTION A	tue.		7/72	3	4	SA		
020 physician. burial-transit	FUN	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	R IN U.S. ARMED			NIC ORIGIN? (Specify Year	or No- 14. RAC	E — American Indian,		
	BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OF	DATES		2 NO Specific	an, Puarto Rican, etc.) /y:	Spe	ck, White, etc.		
ស គួ ន	0		<u> </u>			/			Black		
	ETE	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of life. Do NOT u	work done during me	ON ost of working	16b. KIND OF BUSI	INESS/INDUSTRY			
- B	P.E.	Elementary/Secondary (0-12)	College (1-4 or 5+)	, so nor s	1	_					
AND the hospit detached detached	COMPL	17. FATNER'S NAME (First, Middle, Last)			abore		AME (First, Middle, Malden S	· · · · · · · · · · · · · · · · · · ·			
YLA by the be det	E C	ALIT	hari	Sand		18. MOINERS NA	O	TE 02 0 /	,		
	8	19a. INFORMANT'S NAME (Type/Print)	1400	19b. MAILING	ADDRESS (Street)	and Number or Burni	Route Number, City or Town	State Zin Code			
5 5 5	일	Grace M	hellare.	50	South	2. 170	1 DIE R	State, 210 Code)	4.1 20000		
may be		20a. METNOD OF DISPOSITION	2	20b. PLACE AND DATE		eme of	DATE 20c. LOC	ATION — City or 1	Own. State		
O 6 2 2		1 Donation 5 Other (Specify)		cemetery, crematory or o		m H	1-19-94 /t	- willa	md.		
		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME A	NO ADDRESS OF FA	CILITY / 2/	Wanter 1	Imor Street		
ALTIN death. Pag tuneral di i. examiner											
~ ~ ~		23. PART I. Enter the diseases, or complications that caused the death to not only the mode of diles and a conflict on the conflict on the mode of diles and a conflict on the									
in I in I		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heart failure. List only one cause on each line.									
filled tion, o		IMMEDIATE CAUSE (Final disease Dr condition									
5 5 6		resulting in death) a. TOUTED INDUME DESTRUCTION OF ME									
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OX 68 e be execut sician and c nor to bun traumatic	CATION	Sequentially list conditions,	b DUE TO (OR A	S A CONSEQUENCE O	in:						
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certificate ding physicity giene pr	트	CAUSE (Disease or injury that initiated events	DUE TO (OR A	S A CONSEQUENCE O	F):						
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- B & B -	SA S	PART II. Other significant condition	a contributing to death	but not reaulting	in the underlyin	g cause given in	PERFORM	MED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
7 = P = =	EDIC/						1 D YES 2	> 400	OMPLETION OF CAUSE DF DEATH?		
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Z3 tas t	A	25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE OF			/-				
VIIA AN: The ificate h State (SICIAN:	EXAMINER?	HOSPITAL:		OTHER:	LACE OF DEATH (C)					
CLAN ICLAN	\	1 VES 2 NO 27. MANNER OF DEATN	1 Inpatient 2 ER/O			JURY AT	8 Other (Specify)				
ATTENDING PHYSICIAN: The ECTOR: After this certificate h is after death with the State E a ster death with the State E		1 Natural 5 Pending	(Month, Day, Year		JURY WO	ORK? YES 2 NO	28d. DESCRIBE HOW IN	JUHY OCCURED			
After death		2 Accident Investigation	28s. PLACE OF INJU	IRY — Al home, lerm,			281 LOCATION (Street or	ad Number or Proof	Sauta Number		
TTEND TTEND TOR: /		3 Suicide 8 Could not be 4 Nomicide determined	building, atc. (S	pecify)	allest, factory, offic		281. LOCATION (Street ar City or Town, State)	nd Number or Hurai	Ploute Number,		
- 4 4 5 5		29a. CERTIFIER			- 01-		<u> </u>				
A A S M	MP	(Check only	CIAN: To the best of my kn								
HOSPITAL FUNERAL within 72 h	8		R: On the beals of examine	nion and/or investigation	on, in my opinion, o	seath occured at the	time, date and place, end	due to the cause	a) end manner es stated.		
THE HOSPIT THE FUNER filed within PORTANT:	H	290 SIGNATURE AND TITLE OF CERTIFIE	-	1000		29c. LICENSE NU	MBER	29d. DATE SIGNE	(Month Day, Year)		



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours. The death and be the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- 1		1. DECEDENT'S NAME (First,	Adjulate day of									LG. NO.			
-											2. DATE OF D	EATH DA	Y	YEAR	3. TIME OF DEATH
		JAMES P	ETER	SURGES							Dec 6	199	94	TEAT.	1:25 AM M
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. la:	t birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF 8			a. BIRTI	IPLACE (State or Foreign
- }		212 01 6100		1 🔯 M 2 🗆 F		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De)	r. Year)		Counti	(Y)
		212-01-6100			82	Ing.					April	30,	<u>19</u> 12	Ma	ryland
		9e. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN C	OR LOCATI	ON OF DE	EATH		9c. COU	INTY OF C	DEATH
	<u>ج</u> ا	St. Elizabe	th's N	Jurgino F	Iome		B	21t	imor	e Ci	t- 3.7		Roll	timoı	re City
	DIRECTOR	RESIDENCE OF DEC	EDENT	tarbing i	TOTAL			art.	IMOI	011	<u> </u>		Dai	LIMO	le ofty
	ш	10a. STATE	10b. COUNTY	1		10c, CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
	Œ	Manueland	Do 1 h d			D.									LIMITS?
		Maryland	ватт	imore Cit	.y	_ ва.	Ltimo	re							1 X YES 2 NO
	4	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
	FUNERAL	3320 Benso	n Ave.						212	27			USA	A	
	5	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. AF	MED	13. \	MAS DEC	ENDENT (OF HISPAN	VIC ORIGIN? (Sp	ecify Yea	or No.	14 BACI	E — American Indian,
	1 11	1 Never Married 2 🗵	Merried	FORCES? 1	YES 2 K	90	'	f yes, spe	ecify Cube	m, Mexice	n, Puerto Rican	, atc.)		Blaci	k, White, etc.
	ВУ	3 Widowed 4 Divo	rced	IF TES, GIVE V	WHI OH DATES		_ `	U YES	2 <u>X</u> NO	Specify	γ:			Spec	White
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- 1	ETE	(Specify only	y highest grade		(G	ive kind of	work done o	during mo	st of world	ng	100. KINI	OF BUS	SINESS/INI	DUSTRY	
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ej l	물	8th Grade			Gr	ocer					Frui	Lt &	Pro	duce	Stand
Once.	COMPL	17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOT	HER'S NA	ME (First, Middle	, Maiden	Surname)		70.0
7	_	Pete Surge	S							Catl	herine	Jef	fres		
Hed	BE	19e, INFORMANT'S NAME (7)			19	b. MAILING	ADDRESS	(Street o	nd Numbe		Route Number, C			in Code)	
To T	유	Mrs. Cathy	Rut 102	•										2120	7
be notified at	1			-		_				• Da	altimon				
		20e. METHOD OF DISPOSITI	iON on 3 □ Remo	oval from State	20b. PLACE cemetery, cre			ITION (Ne	me of					City or To	
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쓩		23. PART LEnter the di	seases, or o	complications the	t caused the de	ath. Do	not enter	the mo-	da of dy	ing, sucl	h es cerdiac	or respi	ratory ar	reat,	Approximate
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E,	H	resulting in death)			OR AS A CONSE			. Y		10	100				Louge
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0.0	E	resulting in death) LAS	T C		+1:4)	1-	nv-	$\mathcal{M}_{\mathbf{J}}$	M					
	⊟ E		-												1
in ury,	CAL	PART II. Other algnifica	nt condition	s contributing to	death but not i	asuiting	In tha un	darlying	g cause	given in	Part I. 24a.	WAS AN	AUTOPSY	24b	WERE AUTOPSY PINDINGS AMAILABLE PRIOR TO
any	DIC										1.5	YES 2			COMPLETION OF CAUSE
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or item	3	25. WAS CASE REFERRED TO EXAMINER? \	D MEDICAL	HOSPITAL;	26. PLAC	E OF DEA	TH (Check of								
7.	S	1 TES 2 NO		1 Inpatient 2	ER/Outpatient 3	□ DOA	4 Num		e 5 □ Re	sidence	6 Other (Spe	ecify)			
7	ž	27. MANNER OF DEATH		28e. DATE OF		28b. TIM	E OF	28c. INJ			28d. DESCRIE	E HOW I	NJURY OC	CURED	
죕	\sim		Pending	(Month, D	ay, rear)	INJ	URY M		RK?	NO					
引	m I	2 Charles	Investigation	28e. PLACE C	F INJURY — At he	me ferm	etrant facts				281. LOCATION	1 /0		0 / /	2
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2	-														
=	4	29e. CERTIFIER 1 CERT	IFYING PHYS	CIAN: To the best of	my knowledge, de	ath occurr	ed at the ti	me, date	end place	, end due	to the cause(e)	end men	ner ee ste	ted.	
=	COM		CAL EXAMINE	R: On the beele of e	xemination end/or	Investigation	on, In my o	pinion, d	eath occu	red at the	time, date end	plece, en	d due to fi	he ceuse(e	e) end menner ee stated.
MPORTANT: If					1 1									-	1
NO.	HE I	29b. SIGNATURE AND TITLE	OF CERTIFIER	1	MI		MU		29c. LtC	ENSE NUN	WEER		29d. DAT	E SIGNED	(Moder, Day, Way)
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	F	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type	Print)		0		A			1	
		K	100	\-		3	320		Der	1)c n	A.	1 C VV	FO	11	TCC15 m
	ľ	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	R'S SIGNATURE)	,0			-01	- 11	VV	1	7 1	/
		DEC 0 9 199	14 Jul	in Druction	R'S SIGNATURE										
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3. TIME OF DEATH

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2. DATE OF DEATH

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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DIVISION OF VITAL RECOF

	217-16-4901	5. SEX	6. AGE (In yrs. les	YRS. MON	FHS DAYS	F UNDER 24 HRS. HOURS MIN.	(Mon	OF BIRTH		Country)	CE (State or Foreig
	9e. FACILITY NAME (If not institution,			96.	CITY, TOWN	OR LOCATION OF D		-8-23	9c. COUNT	TY OF DEATH	Md.
OR	Anne Arundel	Medical	Center		Anna	polis		110	Anne	e Arı	ndel
ЕСТО	RESIDENCE OF DECEDEN 10a. STATE 10b. CO			10c. CITY, TO		*					I. INSIDE CITY
DIR	Md.	Anne Arun	del		nanol						LIMITS?
A	10e. STREET AND NUMBER		208			. ZIP CODE			10g. CITIZI	EN OF WHAT	COUNTRY?
E	2900 Shipmas	ster Way-	Annapo	lis.M	d.	21401			T	TS	A
FUNER	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDER FORCES?	T EVER IN U.S. AF	MED	13. WAS DEC	ENDENT OF HISPA ecity Cuben, Mexic	an, Puerto		or No- 1	14. RACE — . Black, WI	Americen Indian hite, etc.
BY	3 Widowed 4 Divorced	7-43	MAR OR DATES	160	1 U YES	2 NO Speci	fy:			Specify:	White
8	15, DECEDENT'S (Specify only highest	EDUCATION	16a, DE	CEDENT'S USUA	AL OCCUPATION	ON and undilar	161	. KIND OF BUS	INESS/INDU		MILL IVE
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	Alder	. Do NOT use reti	red.)	at or working					
MP M	N/A	N/A	Of	fice.	Furn.	Busine				love	-d_
8	17. FATHER'S NAME (First, Middle, Las					16. MOTHER'S NA	AME (First,	Middle, Maiden S	Surname)		
BE		Saulsbury									
2	19e. INFORMANT'S NAME (Type/Print)					and Number or Rural				21	401
	Jane T. Saul	sbury		900 S	nipma	ster W		ht. 20	18- Ar	nanc	lis M
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3	Removal from State	cemetery, cre	AND DATE OF DIS	laca)		DAT			ity or Town,	
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	SE I LOENIGEE	Md. V	etera	is Ce	metery	12-	12-94	Cro	wnsv	rille,
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE				51 Bal		re Na	tion	al T	iko
	G. Trumar	Schwab				ltimor				rorT T	TVC
	23. PART I. Enter the diseases									at,	Approxima
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CATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE OF):							
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Saulsbury

71 0000 THE CONTRACTOR OF VALUE OF S. A. SPAIN LES SECTION OF 1884 of Decimary Section 1884 TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zs. hours after death. Page 6 may be retained by the brospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	C	ERTIFICATE	OF DEA	TH		DEG NO

1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND ATE OF DEATH		GIENE B. NO.	
t. DECEDENT'S NAME (First, Middle, Last)	1			2. DATE OF OEA		3. TIME OF DEATH
Agnes C. S.	telanow.	4		MONTH		YEAR UI 10 AM
			UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRT	гн в	BIRTHPLACE (State or Foreign
215-01-05071	□ M 2 Jo F 7	WRS. MON	THS DAYS HOURS MIN.	(Month, Day, M		Maryland
9e. FACILITY NAME (If not institution, give street	and number)	9b.	CITY, TOWN OR LOCATION OF			Y OF DEATH
mercy medical	Center		Baltimore			
RESIDENCE OF DECEDENT						
10e. STATE 10b. COUNTY			WN OR LOCATION			10d. INSIDE CITY LIMITS?
MD	- <u></u> -	Bal	timore			1 NES 2 NO
10e. STREET AND NUMBER			101. ZIP CODE			N OF WHAT COUNTRY?
2637 Fait A.			21220		US	14
11. MARITAL STATUS 12 1 Never Merried 2 Married	P. WAS DECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxid			I. RACE — American Indien, Black, Whita, atc.
3 NWidowed 4 Divorced	IF YES, GIVE WAR OR D	ATES"	1 TYES 2 SAHO Spec	tty:		specify: white
15. OECEDENT'S EDUCATI	ION	18a. OECEDENT'S USU	AL OCCUPATION	Tab KIND C	OF BUSINESS/INDUS	
(Specify only highest grade corr	npleted)	(Give kind of work iffe. Do NOT use ret	done during most of working	IOU. KIND C	OF BUSINESS/INDUS	ini
Elementary/secondary (0-12)	College (1-4 or 5+)	librar	ian	FE	D. GOVN	MMT.
17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, N		
AUGUST DEMBECK				A KRUPS		
t9a. INFORMANT'S NAME (Type/Print)	**	19b, MAILING ADD	PRESS (Street and Number or Rura			orfe)
mr. brian dembe	ck		ALSTAFF CT.			
20s, METHOD OF DISPOSITION	201	PLACE AND DATE OF DI			Oc. LOCATION CIT	
1 X Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)			CEMETERY		BALTO.	
21. SIGNATURE OF FUNERAL MERINGE LICENS		DAN LAWN	22. NAME AND ADDRESS OF F		DALIU.	MD,
10-11-100	7	0.	KACZOROWSKI		I HOME	_
AUNIL X NO	Mayork	Als 1	2525 FLEET	ST RAI	TO MD	21224
23. PART I. Enter the diseases, or gom shock, Dr heert fellure. List	plications that coused	d the deeth. Do not e	inter the mode of dying, au	ch as cardiec or	respiratory arres	t, Approximate
IMMEDIATE CAUSE (Fine)	Conference Cause Dil e	ech line.				interval Between
						Onset and Death
disease or condition	utecin	e Sara	° 6-ma			
disease or condition resulting in death)	DUE TO (OR AS A	e Sara	coma			Onset and Death
resulting in death)	DUE TO (OR AS A	e Sarc	20ma			
	DUE TO (OR AS A	A CONSEQUENCE OF):	coma			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A CONSEQUENCE OF):	coma			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A	A CONSEQUENCE OF):	coma			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A	A CONSEQUENCE OF):	coma			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF): A CONSEQUENCE OF):		Dect 1		2 mos.
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tending physician. as the burlal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSP TALK ATTEMENT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or att	TO THE FUNERAL	be filed within 72 nows are dear with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	TATE OF MARYL		TMENT OF H		MENTAL HYGI REG.			
1 8	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY	YEAR 3	. TIME OF DEATH
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	212 00 3303 1	₹ M 2 □ F	in yrs. lest birthdey)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year 12/09/)	Country)	ACE (State or Foreign
~	Se. FACILITY NAME (If not institution, give street e	nd number)		9b. CITY, TOWN (R LOCATION OF D	EATH	9c. COL	JNTY OF DEA	тн
DIRECTOR	201 N. Streeper RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	Street	40- 0/7	Balt	imore				
	MD			LTIMORE					Od. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	10e. STREET AND NUMBER	_		101	. ZIP CODE		10g. CIT	IZEN OF WH	AT COUNTRY?
NE	292 SOUTH SPRIN				21231				S.A.
BY	1 V Never Merried 2 Married	WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yee, sp	ENDENT OF HISPA ecify Cuben, Mexica 2 NO Special	NIC ORIGIN? (Specify an, Puerlo Rican, etc. fy:	Yee or No-	14. RACE - Black, V BLAC	- American Indien, White, etc.
0	15. DECEDENT'S EDUCATIO	N	16a. DECEDENT'S	USUAL OCCUPATION)N	16b. KIND OF	BUSINESS/IN	1	
COMPLETED	(Specify only highest grade composition of the comp	lege (1-4 or 5+)	(Give kind of viile. Do NOT us	-	st of working	SI	ELF E	MPLOY	ED
ш	17. FATHER'S NAME (First, Middle, Last) GEORGE ROBERT SC)LOMAN II	I		16. MOTHER'S NA	ME (First, Middle, Mail	den Sumeme) MITC	HELL	
TO B	190. INFORMANT'S NAME (Type/Print) SHARON REDMOND					Route Number, City or BALTIM(21206
	20e. METHOD OF DISPOSITION	20b	.PLACE AND DATE (OF DISPOSITION (No			LOCATION -		
	1 Donation 5 Other (Specify)		etery, cremetory or of LTIMORI	CEMET	ERY	12/10	BAT.T	TMORE	. MD
	21. SIGNATUSE OF FUNERAL SERVICE LICENSE		to	22. NAME AN	D ADDRESS OF FA	BETTS	FUNE	RAL H	HOME MD21213
7	23. PART LEnter the dieeese, or comp shock, or haen dallure. Liet of IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	MULTIPUS	I the deeth. Do nech line.	HOT W		h as cardiac or re	apiratory er	reat,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentielly list conditions, if erry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in deeth) LAST		CONSEQUENCE OF						
PHYSICIAN: MEDICAL C	PART II. Other significent conditions cor	ntributing to death be	ut not reculting i	n the underlying	ceuse given in	PER	AN AUTOPSY FORMED?	Ci	ERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
ž	DID TOBACCO USE CONTRIBU	TE TO CAUSE O	F DEATH YE	S NO	UNCERTAI	N 🗆			^
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	26. PLACE OF DEAT	OTHER.	37				
YS	1 4 YES 2 NO 1	Inpetient 2 - ER/Outp		4 🗆 Nursing Hom		8 Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		URY WO	RK?	28d. DESCRIBE HO			
BY	2 Accident Investigation	12-4-94 280. PLACE OF INJURY	1739		7	ZMBJE	7 31		.10
ETED	3 Suicide 8 Could not be determined	building, atc. (Spec	Al home, larm, s	tregt, lactory, offici		281. LOCATION (Str. City or Town, St. 201 N. ST	LEPE		BALTIUNORE
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On								nd menner se stated.
8	296. BIGGINTURE AND TITLE OF CONTRIBER	A			29c. LICENSE NUI		29d. DAT		lonth, Day, Year)
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH rea ale R. 10:28p 4M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 7 1 2 D F YRS. Pa. Oct. 14, 1922 9a. FACILITY NAME (If not institution, give st 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH Gmore DIRECTOR nove RESIDENCE OF DE EDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Pa. York Yoe Boro. 1 . YES 2 . NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 40 W. Broad St. U.S.A, . 17313 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAA OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Married
3 Widowed 4 Divorced If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 TYES 2 NO Specify: Spectly: White BY COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Cabinet Mfg. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Walter Sprenkle notified at Mary S. Posey BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Virginia R. Sprenkle 40 W. Broad St., Yoe, Pa. 17313 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of must b DATE 20c. LOCATION - City or Town, State Crematory 12/2
22. NAME AND ADDRESS OF FACILITY Vork, pa examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Austin H. Eberly Inc. 104 W. Main St. Dallastown, Pa. medicai 23. PART I. Enty the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line interval Between Onset end Death IMMEDIATE CAUSE (Finsi the disease or condition toutro aneurysm resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST 0 Injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? shows a 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 23 25. WAS CASE REFERRED TO MEDICAL Item ; 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO Inpetient 2 ER/Outpetient 3 DOA Nursing Home 5 - Resid 6 Other (Specify) 5 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Natural M 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Spec#y) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be determined COMPLETED 4 Homicide Item 29s. CERTIFIER
(Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the ation end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTS 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 띪 111 12-1 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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BALTIMORE, MARYLAND 21203-3146	OR ATTICLUS PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physicial	Designation and the cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer and Memial Hygiene prior to burial, cremation, or removal.
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and PHYSICIAN: The law requires that the death certificate be executed within jours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	marked or lies 23 shows any Internal regions prior to other transmitte event the

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR LOUIS SCHWARTZ 6:15 1994 November 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign 14 M 2 □ F DAYS HOURS YRS. 84 053-09-0135 March 1 1910 New York, N.Y. 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1215 Oakleaf Drive. Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring 1 TYES 2 NO Montgomery FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 11215 Oakleaf Drive #1808 20901 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TY YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American indian, Black, White, etc. 1 Never Married 2 X Merried 1 YES 2 XNO Specify: Specify: BY 3 Widowed 4 Divorced White World War II 8 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retred.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ET Elementary/Secondary (0-12) COMPL 12 Yrs Harry Diamond Lab U.S. Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie (Unascertainalbe) BE Isadore Schwartz 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11215 Oakleaf Drive, #1808, Silver Spring, MD 20901 19a. INFORMANT'S NAME (Type/Print) 2 Frances Schwartz 20a. METHOD OF DISPOSITION

15 Burial 2 Cremation 3 R 20b. PLACE OF DISPOSITION (Name of cometery, cremetory 11/30/1994, LOCATION — City or Town, State other place) King David Memorial Garden 4 Donation 6 Other (Specify) Falls Church. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Donald 232 CARROLL ST, NW, WASHINGTON, DC 20012 23. PART I. Enter the diseases, or complications that caused the drafth. Do not enter the mode of dying, such as cerdiac or respiratory errent, shock, or heert feliure. List only one cause on each me. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition_ Immediate Respiratory Failure resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Immediate Aspiration Pneumonia CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Long Standing Cerebrovascular Accidents CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL **MAILABLE PRIOR TO** PLETION OF CAUSE 1 YES 2 XNO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, HOSPITAL: OTHER: 1 YES 2 NO 1 Scinpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 6 🛣 Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 🔣 Natural 6 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER
(Chack only Chack on Chac 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.

29c. LICENSE NUMBER

2101 Medical Park Dr., Silver Spring, Maryland 20902

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29b. SIGNATURE AND TITLE OF CERTIFIER

Ira Paul Krefting

"9°1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

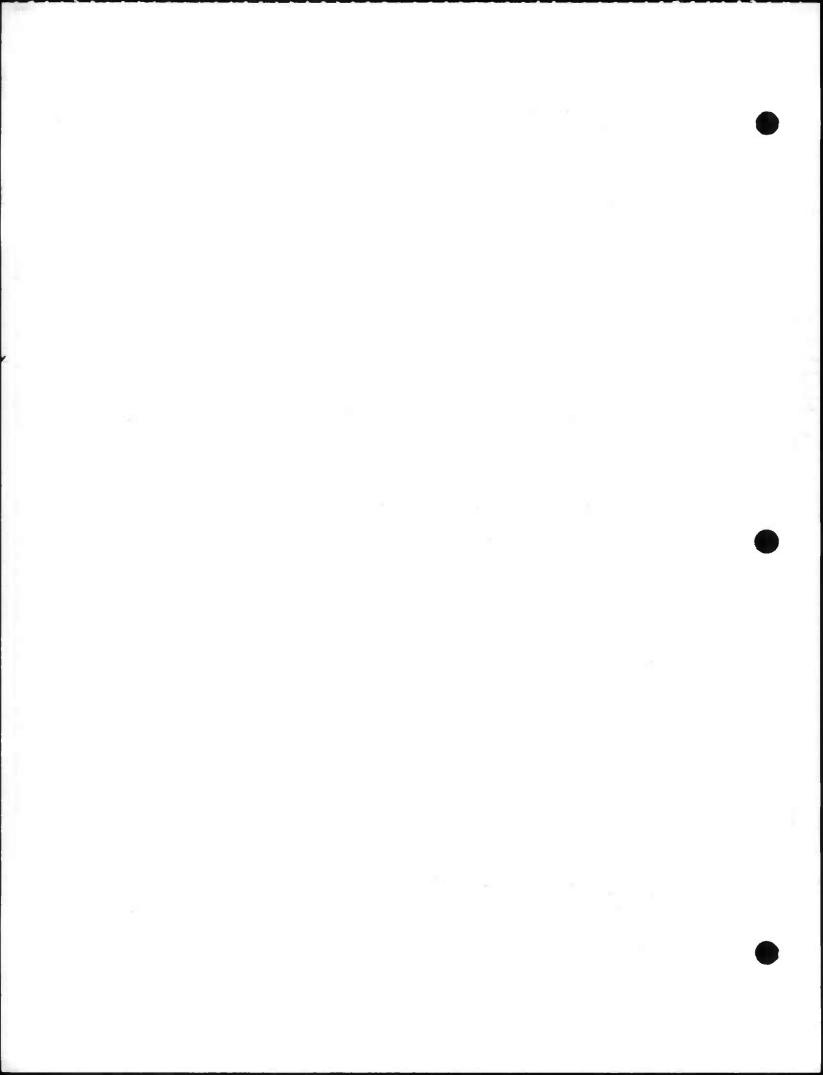
July 32 The State of Rome Line

29d. DATE SIGNED (Month, Day, Year)

Nov. 29, 1994

asp ± Item1 12-9-94 Filmg718 W.H. Per F/H

IN	IQU]	RY FOR 1 - STATE REGISTRAR	STATE OF M			RTMENT OF			MENTA	L HYGIEN	E		
		1. DECEDENT'S NAME Alfred ALFREDO M.	SCOTT							OF DEATH	1994	VEAR	TIME OF DEATH
9	1	040 40 0440	5. SEX 1 M 2 F	6. AGE (In yrs. le 78	est birthday) YRS.	IF UNDER 1 YEA	_	UNDER 24 HRS.	(Mon	OF BIRTH th, Day, Year) -5-191		Country)	ACE (State or Foreign
2. 3 should	стоя	99. FACILITY NAME (If not institution, give street 3711 BEECH AVI RESIDENCE OF DECEMENT	,					RE CI			9c. COUNT	Y OF DEA	тн
it. Pages 1.	DIREC	10e. STATE 10b. COUNTY Maryland			10c. CIT	Y, TOWN OR LO	CATION	Ва	ltin	ore	- 1	od. INSIDE CITY LIMITS? XYES 2 NO	
n. ansit permit.	FUNERAL	10e. STREET AND NUMBER 3711 Beech	Avenue				101. ZIP	2121	11		10g. CITIZE		AT COUNTRY?
5-UUZU nding physician. ss the burial-transit	B≺	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	EVER IN U.S. A YES 2VER R OR DATES	RMED	If yea,	specify	ENT OF HISPAN	NIC ORIGIN? (Specify Yea or No— 14. RACE — Black, W				- American Indian, White, etc. White
al or afte	PLETED			· · ·	Give kind of e. Do NOT u	USUAL OCCUPA work done during se retired.)	most of	working	168	KIND OF BUS Maryl Insur			ualty
be de at on	E COMPL	12+ 17. FATHER'S NAME (First, Middle, Lest) Robert Scott	:					. MOTHER'S NA	ME (First,	Middle, Maiden C. Ed	Sumame)		
retain 5 sho	TO BI	190. INFORMANT'S NAME (Type/Print) Robert Scott		-19	9b. MAILING	3711 E	et and N	umber or Rural P	Poute Num	ber, City or Town	o, State, Zip C	D 2	1211
I. Page 6 may be real director, page		20e. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Remove 4 Donetion 5 Other (Specify)		cemetery cr	emetory or o	Ridge	Cei	metery			kesv		
r death. r funera al. examil		21. SIGNATURE OF TUNERAL SERVICE LICEN	. Cay	sente	1	Bur	ge	odress of fa e-Hens Falls	ss F				21211
the the		23. PART I. Enter the speesea, or corehock, or heart feilure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	et only one cause	ceueed the de on eech lin	e sele	not enter the r	mode o	of dying, auci	h es cen	diec or reepi	ratory arres	it,	Approximate Interval Between
be execucian and for to bur	CATION	Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (C	OR AS A CONSE	OUENCE O	F):							
ending Hygier	ERTIFI	CAUSE (Disease or injury that initiated eventa reaulting in death) LAST	DUE TO (O	OR AS A CONSE	OUENCE O	ጉ :							
requires that the deal een signed by the atl of Health and Merits shows any Injury,	MEDICAL C	PART Other eignificant conditions of	contributing to d	eeth but not	reculting	in the underly	/ing ce	ruse given in	Part i.	24a. WAS AN PERFOR	MED?	A	ERE AUTOPSY FINDINGS WALABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
las been dept. of the 23 short		DID TOBACCO USE CONTRIE	BUTE TO CAU			S NO		UNCERTAIN	۷ 🗆	INQU	IRY	1	YES 2 NO
CLAN: The ertificate the State or Herm	YSICIAN:	EXAMINER? 1X YES 2 NO	OSPITAL:	ER/Outpatient	3 🗆 OOA	OTHER: 4 Nursing H	lome 5		8 🗆 Othe	r (Specify)			
Free tres o	ву РНҮ	27. MANNER OF DEATH 1 Autural 5 Pending 2 Accident Investigation	28s. DATE OF IN (Month, Day,	. Year)	1	M 1		AT 2 NO	28d. DE:	SCRIBE HOW IN	JURY OCCU	RED	
RECTOR.	ETED	3 Suicide 8 Could not be detarmined	28e. PLACE OF building, et	INJURY — At h	ome, ferm, i	itreet, fectory, of	ffica		281. LOC City	ATION (Street a or Town, State)	nd Number or	Rural Rou	te Number,
CS TAL O	COMPL	29e. CERTIFIER 1 CERTIFYING PHYSICIA (Check only one) 2 X MEDICAL EXAMINER:	IN: To the best of m	y knowledge, d	eath occum	ed at the time, do	ate end	place, end due occured at the	to the car	and place, and	ner as stated	ceuse(a) a	nd manner as stated.
TO THE HOSEN TO THE FUNE TO BE BED WITHIN	TO BE	296. SIGNATURE AND TITLE OF CENTIFIER	OCME	IBER				onth, Day, Year)					
(2)		MALSN COL	COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type, L1 Pe	enn St	ree	et, Ba	lti	more,	Mar	ylar	nd 21201
0		31. DATE FILED (Month, Day, Year) DEC 0 9 1994	Jahra Dan	S SIGNATURE	fall								



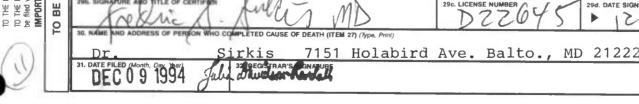
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after death	by the funeral	moval.	
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executed within ze hours after death. Page 6 may be retained by the hos	completel	rial, crema	
ate be exec	ysician and	prior to be	
V: The law requires that the death certificate be executed within	ttending ph	tal Hygiene	
that the de	cate has been signed by the attendir	h and Merr	
w requires	been sign	pt. of Healt	
IAN: The la	tificate has	e State De	
IG PHYSIC	After this certificate has been signed by the attendil	ath with th	
THE HOSPITAL DR ATTENDIN	RECTOR: A!	after	
SPITAL DI	E FUNERAL DIF	thin 72 hot	
TO THE HC	TO THE FU	be filed within 72 hours	

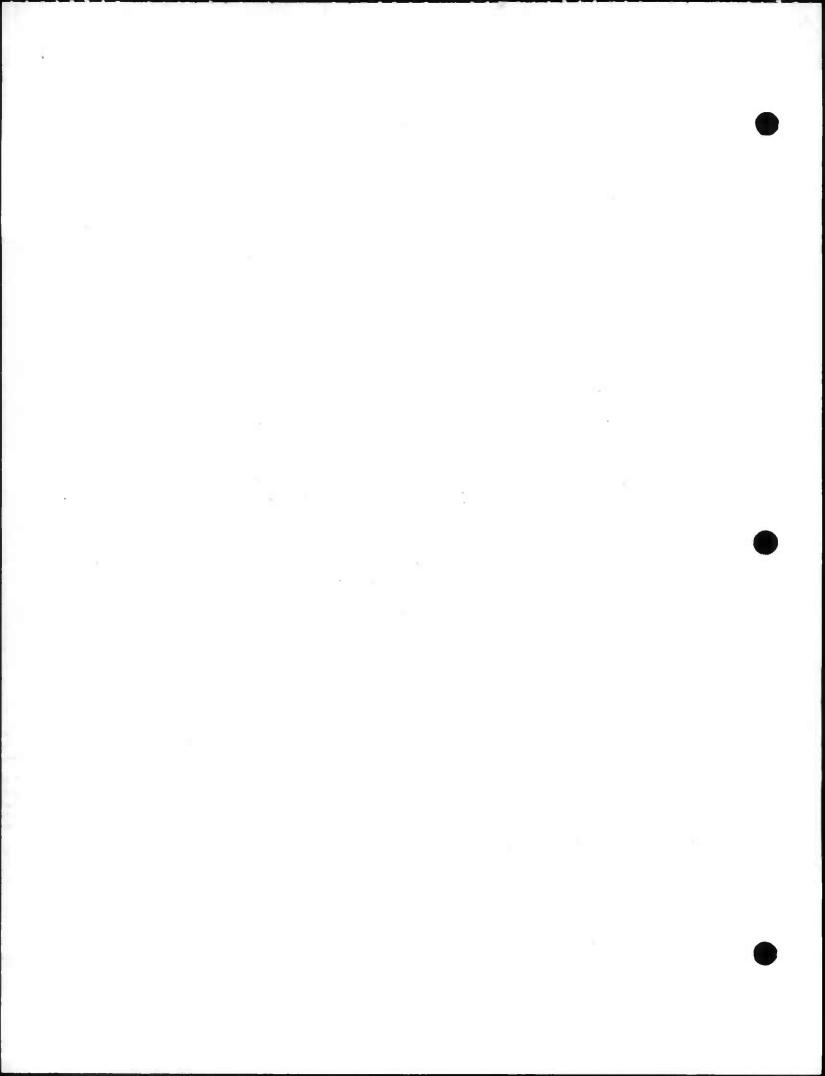
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 12-05-1994 3. TIME OF DEATH Myrtle C. Talbott YEAR 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 3-2-1908 6. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN 1 M 2 F YRS. 212-01-1473 86 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Long Green Meridian N. Home Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO 10a STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1322 Morling Avenue USA 21211 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 3 Widowed 4 Divorced BY Specify: white COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY US Governent & (Specify only highest grade compl (Give kind of work done life. Do NOT usa retired.) et of working Elementary/Secondary (0-12) College (1-4 or 5+) SECRETARY B&O Railroad 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Bunn William Hamilton Ħ BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3702 Beech Avenue Balto., MD 21211 9 Kenneth Boblitz pe 20a. METHOD OF DISPOSITION
1 □ Burlal 2 (Cremation 3 □ Ramoval from Stata
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION - City or Town, State Must Crematory Metro 12/6 Catonsville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Rd Balto., MD 21211 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode onlying, such as cardiac or respiratory arrest, Approximata heart fallure. List only ona cause on each line ahock, interval Betwe IMMEDIATE CAUSE (Final disease or condition Onaet and Death the month event, reaulting in death) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING **CAUSE** (Disease or Injury DUF TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION OF CAUSE 1 TYES 2 NO DF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Chi only one) HOSPITAL OTHER:
4 N Nursing Home 5 | Residence 6 | Other (Specify) 1 yes 2 g No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 26c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Watural 5 Pending 1 YES Z NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suiride 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be COMPLETED 4 Homicida 82 29s. CERTIFIER 1 CERTIFYING PHYSICIAN To my best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 [MEDICAL EXAM stion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER



5



REG. NO.

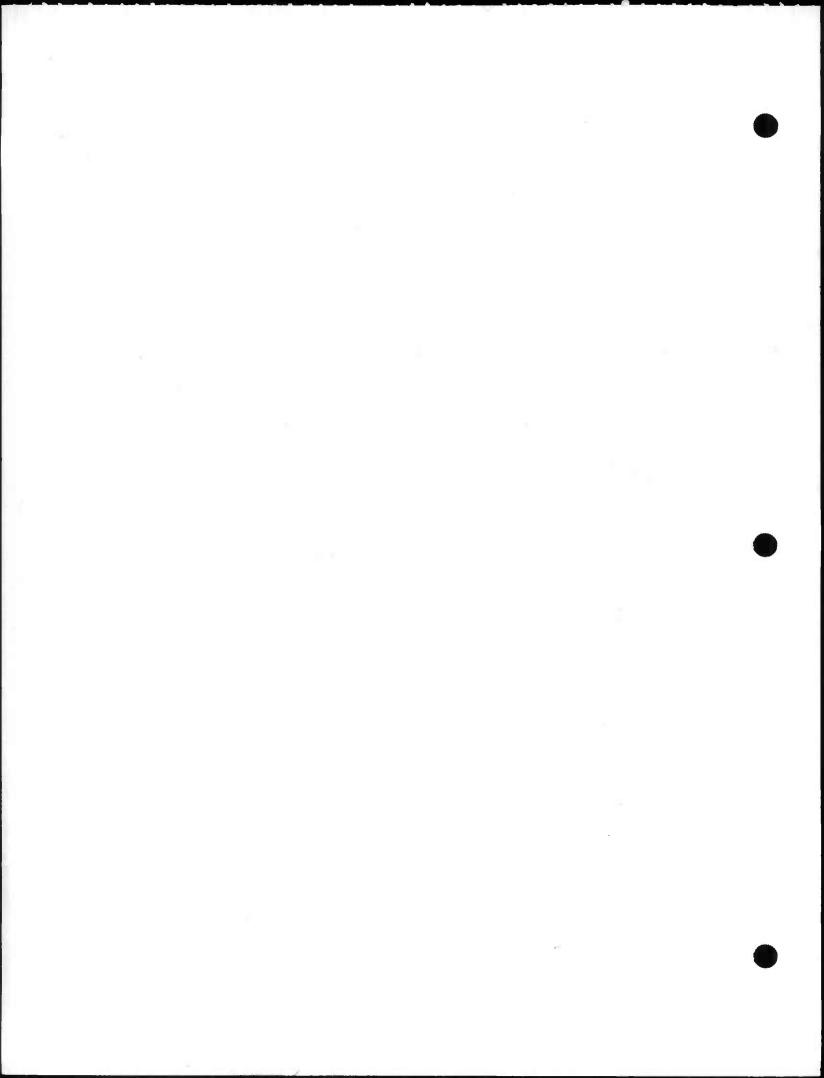
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH IHORF ALYCE 0 1540 12 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. Feb. 18, 1929 DAYS 24 8363 HOURS 1 M 2 X 65 YRS New Jersey Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel Medical Center Annapolis Anne Arundel DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NJ Somerset Warren 1 XYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 28 Mountain Blvd. 07059 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, While, etc. If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Married 2 Merried IF YES, GIVE WAR OR OATES 1 YES 2 X NO Specify White ¥ 3 Widowed 4 Divorced ED. 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Ē Elementary/Secondary (0-12) Remedial Reading Education, Middlesex, N. funeral director, page 5 should be detached COMP Teacher
18. MOTHER'S NAME (First, Middle, Meiden Surname) 17. FATHER'S NAME (First, Middle, Last) George Schwetz Matrona Kreitz ĕ notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen G. Thorp Jr. 28 Mountain Blvd.Warren, New Jersey, 07059 pe 25s. METHOD OF DISPOSITION 1 Disposition 3 Disposition 3 Disposition 3 Disposition Disposi 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION - City or Town, State must □ Donation 5 Nother (Specify) entombmen Hollywood Mem. Park Cem. Union, NJ the medical examiner 21. SIGNATURE OF PUNERAL BERYICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Hardesty Funeral Home, P.A. hours after death. alsu rends 12 Ridgely Ave. Annapolis, MD 21401 the or removal. physician and completely filled in by the prior to burlal, cremation, or remove 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart fellure. List only one ceuse on each line Interval Between IMMEDIATE CAUSE (Finel Onset end Death disease or condition resulting in deeth) Metastatic month event, traumatic CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate death certificate be ceuse. Enter UNDERLYING CAUSE (Disease or injury the attending phy d Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE s certificate has been si th the State Dept, of He id, or Item 23 show 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HQ6PITAL: OTHER: 1 TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) with t 25b. TIME OF INJURY 28c. INJURY AT WORK? 26d. OESCRIBE HOW INJURY OCCURED Is marked, Netural 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, streel, lectory, office building, etc. (Specify) 3 Stilcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 Could not be COMPLETED 28 9 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner ee stated. THE HOSPITAL (THE FUNERAL D filed within 72 h Ξ 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner ee stated. TO THE HOSPITA
TO THE FUNERA
, be filed within 72
IMPORTANT: II 296, SIGNATUSE AND TITLE OF STATIFIER 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) BESTEATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



TO BE COMPLETED BY FUNERAL DIRECTOR

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/17/94 t.t.

1 - STATE REGISTRAR		SIATE OF N	IARYL				NT OF H TE OF			MENTA	AL HYGIEN REG. NO.	E				
1. DECEDENT'S NAME (First,	Middle, Last)										2. DATE OF OEATH SOUTH SEAR 3. TIME OF DEATH SOUTH SEAR SEARCH SE					
Curtis 4. SOCIAL SECURITY NUMB		ee			psor					Dec 04 1994 2315						
212-78-3793		5. SEX	6. AGE	in yrs. last	YRS,	MONT	HS DAYS	HOURS	MIN.	7. DATI	e of BIRTH hth, Day, Year) ember	5. 1	S. BIRTN	PLACE (State or Foreign SC.		
9a. FACILITY NAME (If not ins		street and number)				9b. C	CITY, TOWN C	R LOCATI	ON OF D	_			NTY OF D			
3300 W. Be	lvede	ere Ave.	2n	d f	lr.	E	Balti	more	e							
10a. STATE	10b. COUNT	Υ	-		10c. CIT	Y, TOW	N OR LOCAT	ION _	71.					10d. INSIDE CITY		
Md.								B	altin	nore				LIMITS? 1 K YES 2 NO		
10e. STREET AND NUMBER	2 - 1						101	. ZIP COD		-		10g. CIT		HAT COUNTRY?		
5802 Simmon	ds Ave	12. WAS DECEDEN	T EVER IN	LUS ARA	4ED	_	13 WAS DEC		2121		IN? (Specify Yes	es No	US			
1 Never Married 2 4 3 Wildowed 4 Divor		FORCES? 1 8/19/82	YES YES	2 N	0			ecify Cubi	n, Maxica	in, Puarto	Rican, atc.)	U NO-	Black	— American Indian, , White, atc. ^{fy:} Black		
15. DECI (Specify only	EDENT'S EDU highest grade	CATION completed)		(Giv	re kind of t	work do	L OCCUPATIO	N st of workli	ng	16	b. KIND OF BUS	INESS/INE	DUSTRY			
Elementary/Secondary (0- 1.2.th	-t2)	College (1-4 or 5 a	-)	life.	Do NOT U		id.)				Tni	restm	ont			
17. FATNER'S NAME (First, Mil	iddle, Last)	J 918			OHE	2.1.		ts. MOT	NER'S NA	ME (First.	Middle, Maiden		ieiro			
Lonnie Tho	mpson										llips					
19a. INFORMANT'S NAME (1)											mber, City or Town			. 01 03 5		
Irene Thom	-			_		_			enue					d 21215		
20b. PLACE AND DATE OF DISPOSITION OATE 20b. PLACE AND DATE OF DISPOSITION (Name of Competing of																
21. SIGNATURE OF FUNCHAL	21. SIGNATURE OF FUNERAL SERVICE-LICENSEE 22. NAME AND ADDRESS OF FACILITY Caple Funeral Service															
1)	Jana	- B.C	5	K	_		5502	Winr	ner /		-					
5502 Winner Avenue Baltimore, Md. 21215 PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert fallure, fist only one cause on each line. Approximate interval Between																
IMMEDIATE CAUSE (Fin disease or condition		Z. 01 01.1, 01.0 02.0	00 011 01	2011 11110.										Onset and Death		
resulting in death)	→	e. NARCOTIC	OR AS A			Pi:										
		b.				,										
Sequentially list condition if any, leading to immediate cause. Enter UNDERLYII	liate	DUE TO	(OR AS A	CONSEO	UENCE O	F):				-						
CAUSE (Disease or Injur		cDUE TO	OR AS A	CONSEO	UENCE O)-				-						
resulting in death) LAST	· [d														
PART II. Other algolitices	nt condition	na contributing to	death be	ut not re	aulting	in the	underlying	Cause	piven in	Pert I.	24a. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS		
							,				PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
														OF DEATN? 1 YES 2 NO		
DID TOBACCO US	_	RIBUTE TO CA						UNC	ERTAI	N						
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:				OTH	eck only one)			17		1				
1X YES 2 NO 27. MANNER OF DEATN		1 Inpetient 2 I	INJURY	itlent 3	28b. TIM		Nursing Home 28c, INJ		sidenca		er (Specify) a		cene			
	Pending nvestigation	12-4-94			FOUND	URY	WOI	RK?	X NO	UNKN						
3 Suicide 6 KX	Could not be	28e. PLACE Of building,	F INJURY	— At hon	ne, farm, :	street,	factory, office	1			CATION (Street a	nd Number	or Rural A	oute Number,		
	ietarmined		_	UN	KNOWN							UNKNO)WN			
		ICIAN: To the bust of												and manner as stated.		
29b. BIGMÂTURE AND TITLE	-	-	- In the second	andor in	ivoatigatio	41, IFI IT	ny opinion, oi				a and place, and					
Muy	中里	2VI	-/	n i					ENSE NUM		, [(Month, Day, Year)		
30. NAME AND ADDRESS OF	REASON WH	O COMPLETED CAUS	E OF OEA	TN (ITEM	27) (Туре,	Print)			r.C.	IVI H		ne.	<u> </u>	5 1994		
MARIO F.	an	W JEW	110	11	1 Pe	enn	Str	eet	Ba	lti	more.	Mar	yla	nd 21201		
DEC 0.3.13	94	W William	TO STATE OF													

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	permit. Pages 1, 2, 3 should		
hospital or attending physician.	lor, page 5 should be detached for use as the burlat-transit permit. Py		Ce.
24 hours after death. Page 6 may be retained by the hospital or attending	22		ulner must be notified at once.
executed within 24 hours after death	nd completely filled in by the funeral dire	rial, cremation, or removal.	tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examin
å	the attending physician a	and Mental Hygiene prior to bu	y injury, or other traumat
YSICIAN: The law requires that the death certificate	s certificate has been signed	mours after death with the State Dept. of Health and	ed, or item 23 shows an
OR ATTENDING PH	DIRECTOR: After this cert	mours after death w	Item 28 is mark

R ATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MAR		DEPAR					MENT	AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	ShKoff							2. DAT	E OF DEATH	3 - c	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 297 28 1580	5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day Year) AUG 24 190							B. BIRTHPLACE (State or Foreign Country) Onlo					
TOR	9a. FACILITY NAME (If not institution, give: Suburban Hospita RESIDENCE OF DECEDENT							ON OF D	EATN				y of DEATH COMETY	
DIRECTOR	10e. STATE 10b. COUNT	gomery	10c. CITY, TOWN OR LOCATION ROCKVILLE								10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 5901 Montrose Roa	5901 Montrose Road						€ 2 – 47	48		WHAT COUNTRY?			
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	RMED NO	1	If yes, spe	ENDENT Countries	in, Maxica	in, Puerto	IN? (Specify Yes Rican, atc.)	or No-	Blac	E — American Indian, k, White, etc.			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Religious													
BE COM	17. FATHER'S NAME (First, Middle, Last) Julius Tishkoff			icac	IICI			NER'S NA		Middle, Maiden				
TO B	190. INFORMANT'S NAME (Type/Print) Julian Tishkoff		-							nber City or Tow le, Md		,	2749	
	20s. METHOD OF DISPOSITION Solution 2 Cremetion 3 Removal from State											• • • • • • • • • • • • • • • • • • • •		
	V Serverdon	Markey							I F	alls C	hurch	,Va.	neral Home .22046	
23. PART I. Entar the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or reapiretory streat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									est,	Approximate interval Batween Onset and Death Imm Juhan Juhan May 1971 -				
4	Chronic browliting, employence dainy drutting dense tie PERFORMED? CON										WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
BY PHYSICIAN: MEDIC,	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE	_	ATH YE			UNC	ERTAI	V 🗆			\perp	1 YES 2 NO	
IYSICI	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1)Q Inpatient 2 ER/	Outpatient 3		OTHER 4 Num	t: sing Nome		esidenca		er (Specify)				
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ar)	INJI	JRY M		RK? ES 2	NO		SCRIBE HOW I			Doub Number	
LETED	4 Nomicide determined	building, etc. (Specify)		=				City	or Town, State)			and Hampen,	
COMPL	(Check only CERTIFYING PRYS	CIAN: To the best of my k											a) and manner as stated.	
TO BE	296. SIGNATURE AND TITLE OF CERTIFIED	hen, MD	atte	Jane	الي ري	iles.	29c. LICE	O 1/	4BER				(Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON WAS	Mr) 1210	chy r		4	مر	Rec	Cill	3	mp -	2115	2.		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	END	R: A	92	
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	PITAL	PAIL 2		
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be duranthed fun be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burkal, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - STATE REGISTRAR		STATE OF I	MARYLAN	ID / DEPAR Certif					MENT	AL HYGIEN REG. NO			
8	1. DECEDENT'S NAME (First, A	Middle, Last)	Tishi	a Willi						2. DA	TE OF DEATH		994*	3. TIME OF DEATH 23:45
	4. SOCIAL SECURITY NUMBER		i. SEX	_	rrs. last birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DA	E OF BIRTH		_	IPLACE (State or Foreign
	219-37-7759 90. FACILITY NAME (If not insti		□ M 2 💢 F	$\frac{m^2 \sqrt{\chi^2}}{2}$ 1 Yes. 9 25 FEB.11, 199						MAR	YLAND			
H.	THE JOHNS H				ORE (EATH		9c. COU	NTY OF D				
2	RESIDENCE OF DECE													
DIRECTOR	MARYLAND	MARYLAND n/a					LTIM							10d. INSIDE CITY LIMITS? 1/1/ YES 2 NO
MAL	10e. STREET AND NUMBER			101	I, ZIP COD						VHAT COUNTRY?			
FUNERAL	1612 E. (OLIVER	STREE								NII -	UNI		STATES
論	1 Never Merried 2 M 3 Widowed 4 Divorce	larried	FORCES? 1 IF YES, GIVE W	YES 2	EVER IN U.S. ARMED 19. WAS DECEMBENT OF HISPANI If yea, specify Cuban, Mexican 1 YES 2 X YO Specify:					n. Puerl	iiN7 (Specify Yes o Rican, etc.)	E — Americen Indien, k, White, etc.		
OIL.	(Specify only h	DENT'S EDUCAT	mpleted)		Give kind of life. Do NOT us	work done	durina mo	ON asl of working	19	1	6b. KIND OF BUS	SINESS/INC	DUSTRY	
P.	Elementary/Secondary (0-12	2)	College (1-4 or 5 -	-)	BABY	se reared.)					n	/a		
COMPL	17. FATHER'S NAME (First, Midd										, Middle, Maiden	Surneme)		
BE	CARL WIL				105 MAIL INC	ADDRES	P (Stand o		LATI		EDWA			
2	VERONICA		.IAMS		3237						LTIMORE			213
	20e. METHOD OF DISPOSITION 1 to Squrie 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Competers, crematory or other place) KING MEMORIAL PARK 12-12 RANDALL STOWN,													
	21. SIGNATURE OF FUNERAL	SERVICE LICEN	SEE			22.	NAME AN	ND ADDRE	SS OF FA	CILITY				
	Juen	- 1	lle-								-1101			AVENUE
	23. PART I. Enter the disc shock, or hea	eases, or con ort failure. Lis	npilcationa tha t only ona cau	t cauaad th	a daath. Do r lina.	not anter	tha mo	da of dy	ng, suc	h as ca	rdiac or reapi	ratory ari	reat,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CARDIAC DYSFUNCTION												Onset and Death 4 Ites.	
	DUE TO (OR AS A CONSEQUENCE OF):													6 HRS
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CERTIFICATION	that initiated eventa resulting in death) LAST	d.	502 10	(On AS A CO	INSECUENCE OF	7.								
	PART II. Other algnificant	conditions	ontributing to	death but r	not resulting	n the ur	nderlying	Cause (ivan in	Part I	24a, WAS AN	AUTOPSV	245	WERE AUTOPSY FINDINGS
ICAL	PULMON						,,	,			PERFOR	MED?	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	CHRONIC	LUN	G DIS	EASE								2,410		DF DEATH? 1 ☐ YES 2 € NO
AN:	DID TOBACCO USI		BUTE TO CA					UNC	ERTAIN	1 🗆				
PHYSICIAN: MEDI	EXAMINER?	Н	OSPITAL:		PLACE OF DEAT	OTHE	R:	• 5 □ B•	aldence	6 T O	her (Specify)			
РНҮ	27. MANNER OF DEATH		28a. DATE OF (Month, De	INJURY	28b. TIM		28c. INJ		alderice		ESCRIBE HOW II	NJURY OC	CURED	
ВУ	- Laboratin	ending restigation	28- PLACE O	E IN ILIDY	At home, lerm, s	М	1 🗆 1	YES 2	NO					
ETED		ould not be termined	building,	etc. (Specify)	At Itolie, Ierin, I	Areet, tect	lory, orner			281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)				
COMPLETED			N: To the best of On the basis of ex) end manner ee stated.
BE	Peter Radiel							29c. LICE	NSE NUN	IBER			E SIGNED	(Month, Day, Year)
TO	30. NAME AND ADDRESS OF P PETER RADE					Print)								
	31. DATE FILED (Month, Day, Year DECO 9	1994	32. REGISTRA	S SIGNATU	He Physical	-	_		-					

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STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 1994 CEMBER 11:45 MILDRED WHEATLEY DE AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 DAYS HOURS VRS Pages 1, 2, 3 should 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY DIRECTOR 854 ABBOTT COURT BALTIMORE 10a STATE 10h COUNTY 10d. INSIDE CITY YES 2 NO permit. FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Guban, Maxican, Puarto Rican, atc.)
1 YES 2 ANO Specify: WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian 2 Married В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Page 6 may be retained by the hospital Once. notified at BE 2 pe Taur? the funeral director, medical examiner executed within 24 hours after death. the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. the biseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart fallura. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death the disease of condition Arteriosclerotic Cardiovascular Disease resulting in death) or other traumatic event, OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING DIVISION OF VITAL RECORDS, P.O. BOX OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST this certificate has been signed by the atter with the State Dept. of Health and Mental Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 23 shows any ALZHEIMER'S DISEASE 1 - YES 2 NO OF DEATH? 1 TYES 2 TONO INQJIRY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) item HOSPITAL OTHER: 1XXES 2 □ NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 553 Realdence 5 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural Pending investigation 1 TYES death В 2 Accident DIRECTOR: After 28a. PLACE OF INJURY — At home, ferm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be hours after 28 4 Homicide TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2 29a, CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: Ind/or Investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29c LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE DECEMBER .M.E 1994 2 USE OF DEATH (ITEM 27) (Type, Print) Penn Street, Baltimore, Maryland

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

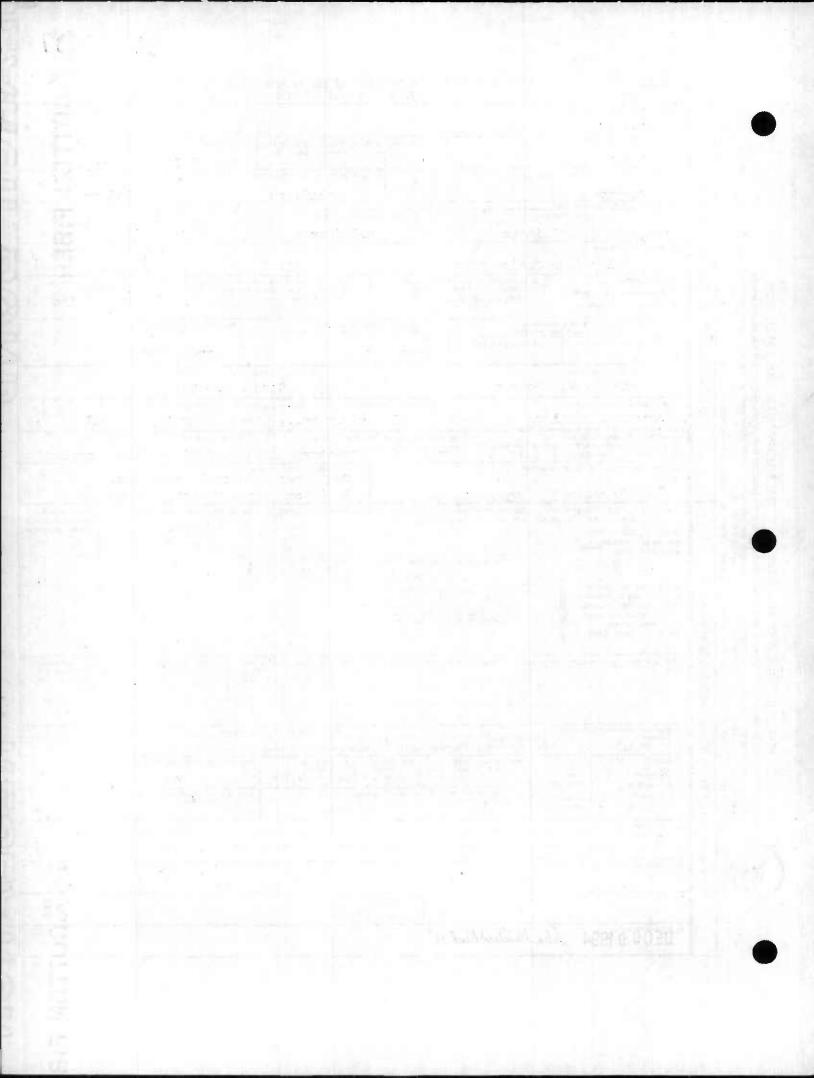
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BALTIMORE, MARYLAND 21215-0020	
68760,	

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

NG PHYSICIAN: The law requires that the death certificate be executed with rours after death. Fage 6 may be reflained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	tion, or removal.	the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	JO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	De field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

011 -1	isl)		CATE OF		2. DATE OF DE	G. NO.	YEAR	3. TIME OF DEATH
RUTH	H. WILN				13	08	94	4:50 A.
4. SOCIAL SECURITY NUMBER 220-05-9130	5. SEX 6. A	AGE (In yrs. last birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIF (Month, Day,	Ybar)	8. BIRTI Count	HPLACE (State or Foreign ry)
9a. FACILITY NAME (If not institution, gf	Δ	76 YRS.	9b. CITY TOWN	OR LOCATION OF D		-1918	UNTY OF E	Maryland
Charlestown				ltimore				
RESIDENCE OF DECEDENT							Balt.	imore
		10c. CITY	, TOWN OR LOCA					10d, INSIDE CITY LIMITS?
Maryland Ba	ltimore		Baltim	ore		10a CC	TIZEN OF	1 YES 2 NO
701 Maide	n Choice Lan	ie		21228			U.S.2	
11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Spe	cify Yee or No-		E — American Indian, k, White, etc.
1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? t \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			Decify Cuben, Mexico Specific Specific		etc.)		White, etc. White
15. DECEDENT'S E (Specify only highest gr		16s. DECEDENT'S I	USUAL OCCUPATE rork done during me e retired.)	ON ost of working	16b. KIND	OF BUSINESS/IN	OUSTRY	No Establish
Elementary/Secondary (0-12)	College (1-4 or 5+)	Secret			No	xell Co	rn	
12 17. FATHER'S NAME (First, Middle, Last)		200100		16. MOTHER'S NA				
Harry V.	Houser			Gar				
19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO	AOORESS (Street	and Number or Rural			(ip Code)	
Robert H. Boub	litz	811	9 Rider	Ave., T	owson,	Marylan	d 212	204
20e. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 R	lemoval from State	20b. PLACE AND DATE O	FDISPOSITION	ame of	OATE	20c. LOCATION -	- City or To	own, State
4 Donation 6 Other (Specify)		Druid Rid	ge Ceme	tery 12	-9-94	Pikesv	ille	, Maryland
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	0	22. NAME A	ND ADDRESS OF FA	Funera	Home	Tng	
Wordlord	00 .1							
o-un-uni	3-131003	ed.				•		
23. PART i. Enter the diseases, shock or heart falls	or complications that car	used the deeth. Do n	105	0 York R	oad, To	wson, M	d. 21	L204
shock, or heart fally IMMEDIATE CAUSE (Final	or complications that care. List only one cause of	used the deeth. Do non each line.	105	0 York R	oad, To	wson, M	d. 21	1204
shock, or heart fallu	re. List only one cause of	on each line.	105 ot enter the mo	0 York R	oad, To	wson, M	d. 21	Approximate Interval Between
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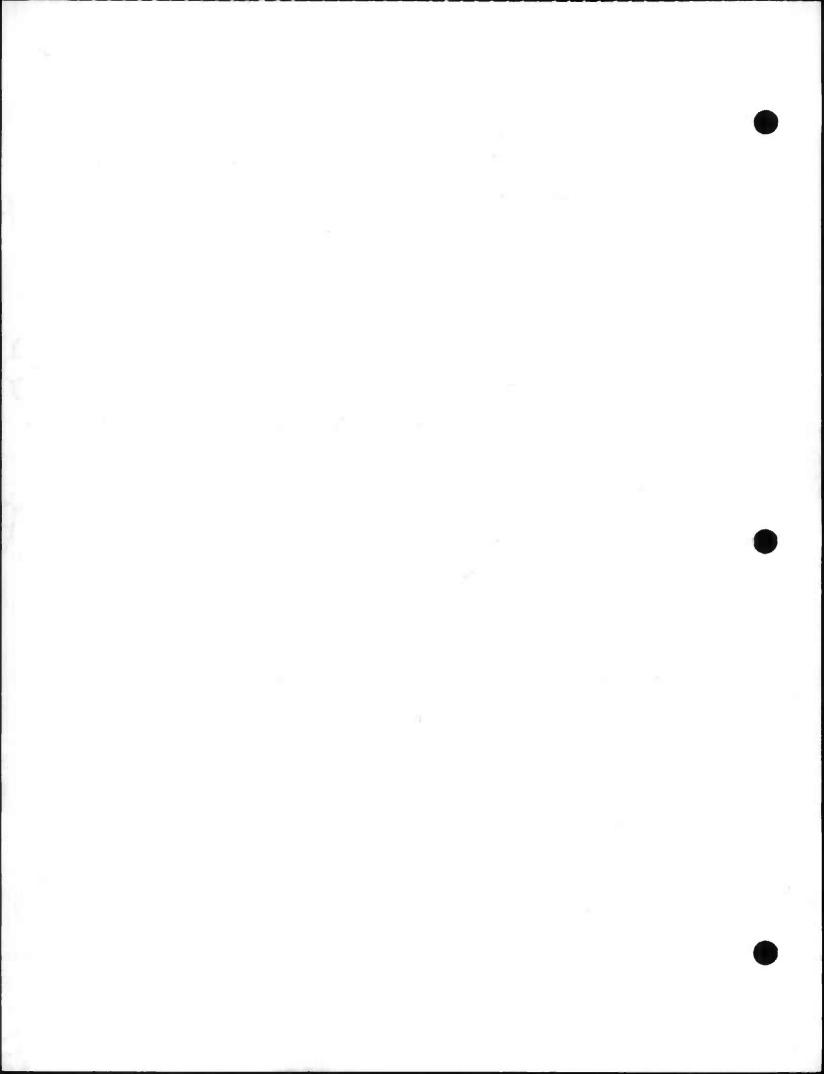
DIVISION OF VITAL RECORDS, P.O. BOX 68760

THENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hospital or attending physician.

In the law the this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached by the Hasth and Mental Hygiene prior to burial, cremation, or removal.

In 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. THE THENDING PHYSICIAN: The law requires that the death certificate be executed within 24 TO THE HEATH TO THE FLEEN Be filed WITH I

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND I	MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
3	DELANA J WAT	KINS				DECEMBER .	3 1994	2:56 P M
		The second second	MO.	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign
		☐ M 2 [X] F	Z 1 YRS.			06-09-73		Μ̈́D
~ l	9e. FACILITY NAME (If not institution, give etreet				OR LOCATION OF DE	EATH	9c. COUNTY OF E	DEATH
<u> </u>	THE JOHNS HOPKIN	S HOSPITAL	I B.	ALTIMO	RE CITY			
RECTOR	10e. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?
5	MD			BALTI	MORE C	ITY		XXYES 2 NO
¥	100. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	1202 N. LUZERNE					1213		S.A.
	1 Never Married 2 Merried	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yee, sp	ecify Cuben, Mexica	HC ORIGIN? (Specify Yes n, Puerio Rican, atc.)	Blac	E — American Indian, k, Whita, etc.
B	3 Widowed 4 Divorced	IF 1ES, GIVE WAN ON DA	IES	I I I YES	2 XNO Specify	y:	BI BI	ÄCK
	15. DECEDENT'S EDUCATI (Specify only highest grade con		16e. DECEDENT'S USL			16b. KINO OF BUS	INESS/INDUSTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	UNEMPLO	·				
COMPL	17. FATHER'S NAME (First, Middle, Last)		ONEMPLO	TED	40 4000110010 444	***************************************		
		WATKINS			JACQUE	ME (First, Middle, Maiden :		
8	19e. INFORMANT'S NAME (Type/Print)	WIIIKING	19b. MAILING AD	DRESS (Street a		SULINE D	AVIS	
2	SARAH TAYLOR		1202 N	. LUZ	ERNE AV	/E. BALTI	MORE, N	ID. 21213
	20e. METHOD OF DISPOSITION 1		PLACE AND DATE OF D	ISPOSITION (Ne			CATION City or To	
	4 Donation 5 Other (Specify)	RA'	LTIMORE	CEMET	ERY	12/8 BA	LTIMORE	E. MD.
	21. SRUNGIUME OF PUMERIAL SERVICE INCENS	SEE	1.		D ADDRESS OF FA	BETTS	FUNERAI	
	Durry (romari	le			DLINE ST.		MD21213
	23. PART Enter the diseases, or com- shock, or heart fellure. List IMMEDIATE CAUSE (Final disease or condition	iplications that caused tonly one cause on as	the death. Do not sch line.	entar the mo	de of dylng, sucl	h as cardiac or reapid	retory arrast,	Approximate Interval Between Onset and Death
ł	reaulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):					Jules
z	•	PINOC	My Ais	5				Innoth
HILCALION	Sequentially list conditions, if any, leading to immediate	DUE TO JON AS A	CONSEQUENCE OF):		01 -0			8.00
	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events	DUE TO JOH AS A	CONSEQUENCE OF:	105 (Ibuse			O YKS,
	resulting in death) LAST	0.000	ACCUSATION OF THE PARTY OF THE	0				1 /
S	PART II. Other aignificant conditions c	contributing to death by	it not requising to a	ha amatantate	anne chies t	Boot I do una		
3	Add conjuntors	115/000	Sund Anna	ne undariyin	cause given in	Part I. 24e. WAS AN / PERFOR		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDIC	he material	hama in	ynume) POP	Sundaine	1 YES 3	X NO	OF DEATH?
25. WAS CASE REFERREO TO MEDICAL 26. PLACE OF DEATH (Check only one)								
	EXAMINER?	OSPITAL: Inpatient 2 - ER/Outpe		THER: Nursing Hom	e 5 🗆 Residence	6 Other (Specify)		
	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		URY AT	28d. DESCRIBE HOW IN	JURY OCCURED	
5	2 Accident Investigation			M 1 🗆			_	
MPLEIEU	3 Suicida 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Special	— At homa, farm, stree fy)	it, factory, offic	·	281. LOCATION (Street a: City or Town, State)	nd Number or Rurel i	Route Number,
ž		N: To the best of my knowle	edge, death occurred at	t the time, date	end place, end due	to the cause(e) and men	ner ee stated.	
5	0/10) 2 MEDICAL EXAMINER: 0	on the basic of examination	and/or investigation, in	n my opinion, d	eath occured at the	time, data and place, end	due to the cause(e) end menner ex stated.
i I	296. SIGNATURE AND TITLE OF CENTIFIER	m			29c. LICENSE NUN	ABER 1 1502	29d. DATE SIGNED	(Month, Day, Year)
2 ∥	30. HAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Prir	n),	JAM	10001	12	5/7
	Soft Days	X GOON	oth Wol	18 SVI	A Joh	in Markey	BOHIN	we 21387
	31. DATE FILED (Month, Day, Year) DFC 0 0 1004	32. REGISTRAR'S SIGNA	TURE			1 3,		
		P WILLIAMS WOOD	/a//					



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH CEDRIC WHITHERSPOON Cedric Demond Witherspoon PM DEC 0.5 1994 9:57 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 9-1 🔛 M 2 🔲 I 19 YRS. 216-90-4828 MD Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR JOHNS HOPKINS BAYVIEW HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY foc. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE 1 X YES 2 | NO permit. 10e. STREET AND NUMBER FUNERAL 10g CITIZEN OF WHAT COUNTRY? 130 N. AISOUITH ST. APT 3.J 21202 bunial-transit U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 RO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Married 2 100 If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify. BY 3 Widowed 4 Divorced page 5 should be detached for use as the BLACK ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) UNEMPLPOYED COMPL once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at ALBERT WITHERSPOON, LINDA HAYNIE 띪 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 LINDA HAYNIE 130 N. AISQUITH ST. APT 3J BALTO, MD21202 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1 Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) the funeral director, CEMETERY ZION LANSDOWNE, MD 0 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME nours after death. 1129 N. CAROLINE ST. BALTO, MD21213 23. PARTA. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory streat, signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo shock, or heart fallure. List only one cause on each line. intarvai Betwe IMMEDIATE CAUSE (Final **Onset and Daath** the disease or condition other traumatic event, resulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, lasding to immediata cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in daath) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any YES 2 NO OF DEATH? Shows 1 YES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? OTHER: 1X YES 2 NO 1 Dinpetient 2 X ER/Outpetient 3 DOA 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, INJURY 2055 1 Natural 1 YES BY After 1 death 2 Accident Investigation 28e. PLACE OF INJURY - At home, farm, street, facto Sulcide 281. LOCATION (Street 28 Is 6 Could not be DIRECTOR: / COMPLETED (70) If Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated THE FUNERAL D HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: II 2 X MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 396 MONATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 出 BE DEC 06,1994 OCME 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) REGISTRAR'S SIGNATU

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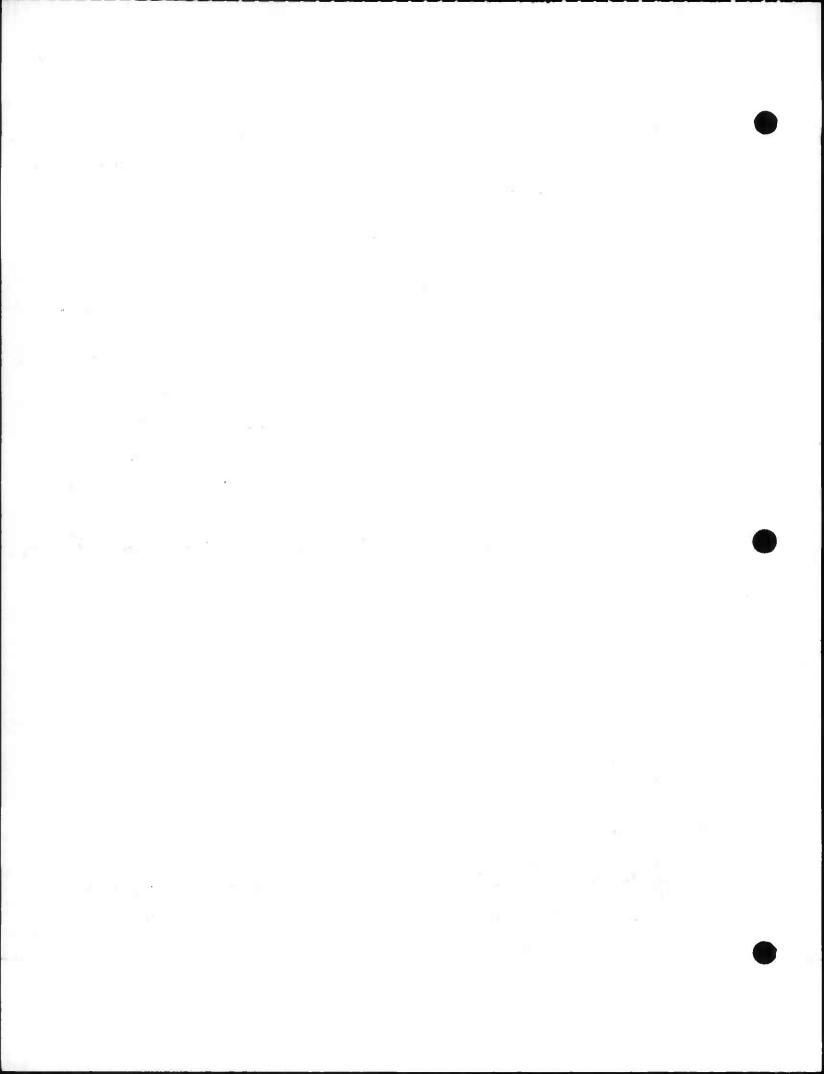
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-hours after death. Page 6 may be retained by the hospital or attending physician.

WRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should nuts after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Example 1 and 1 and 2 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	REGISTRAR		C	ERTIFI	CATE OF	DEATH	R	EG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF C				3. TIME OF DEATN
- 2	Hattie Marie W	right					Dec.	6		YEAR	9:45 A.M
- 1	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. Ia	et birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B		1		PLACE (State or Foreign
	217-16-2892	1 🗆 M 2 😾 F	77	YRS.	MONTHS DAYS	HOURS MIN.	(Month, De	y, Ybar)	<u>.</u>	Countr	ν)
	9a. FACILITY NAME (If not institution, give s	treet and number)			Sh CITY TOWN C	R LOCATION OF D	Feb.	1, 1		Mar NTY OF O	yland
œ		· ·	n - 1 + - 1	ŀ			EAIN		1000		
Carroll County General Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Carroll 10c. CITY, TOWN OR LOCATION Mt. Airy 10c. STREET AND NUMBER 4643 Ridge Road 10f. ZIP CODE 21771 Un 11. MARRITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 XINO 11. Ves. specify Cuben, Maxican, Puerto Rican, stc.)								Car	rol1		
E I	10a. STATE 10b. COUNT	Y		10c. CITY	, TOWN OR LOCAT	ION					10d, INSIDE CITY
E	Maryland Can	roll		Mt	. Airy					- 1	LIMITS?
91	10e. STREET AND NUMBER					ZIP COOE			10a CITI	ZEN OF V	VHAT COUNTRY?
R	4643 Ridge Road										States
Ž	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN ILC AS	OMEO.	112 110 000	21771 ENDENT OF NISPAI					
E	1 Never Married 2 Merried	FORCES? 1	YES 2 K	NO	II yea, spi	cify Cuban, Maxica	in, Puerto Rican		or No.		— American Indian, t, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES		1 TYES	2 NO Specif	ly:			Speci	White
0	15. DECEDENT'S EDU	CATION	16a, Di	CEDENT'S	USUAL OCCUPATION	IN .	185 KIN	D OF BUS	INESS/INC	VISTOV	WILLEE
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(0		rork done during mo.		1000 11111	0 01 000		,001111	
7	8th grade	Conege (I-4 of 5+)		L.P	N		Snr	inaf	1614	Sto	te Hospital
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			11.1		18. MOTHER'S NA				Dea	ice nospical
Ö	John W. Beaver						e Amand		,		
H	19a. INFORMANT'S NAME (Type/Print)		10	6 MAILING	ADDDESS /Street a	nd Number or Rural				0 - 4-1	
2	Mr. Thomas C. Wri	oht Cr				ad Mt.			2177		
	20a, METHOD OF DISPOSITION	igne, si.			FDISPOSITION (Na		DATE DATE		CATION -		
	1 Buriel 2 Cremation 3 Ram	oval from State			her place) emation,		1				2.55525
- 1	4 Donation 5 Other (Specify)	ENSEE	Juarro	II Cr		D ADDRESS OF FA	12//	нап	npste	ad,	Maryland
	11	20		_		r-Queen		al Di	irect	ors.	P.A.
	James a	5 00	cy							-	d, MD 21784
	23. PART L Enter the diseases, or	complicatione that	caused tha de	eath. Do n	ot entar the mo	da of dying, suc	h aa cerdiac	or raepli	ratory err	eet,	Approximate
	ahock, or heert fellure. IMMEDIATE CAUSE (Final					1					interval Batween Onaet and/Death
1	disease or condition	TROGET	SEILE	NO	DN-40!	XXIN'S	14Y1	MPF	101	IA	# 411K
	reaulting in death)		OR AS A CONSE			3011117			0-1	- 1	CD 1413
2											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (C	R AS A CONSE	OUENCE OF	7:						
8	cause. Enter UNDERLYING	c.									
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (C	R AS A CONSE	OUENCE OF):						
듄	resulting in deeth) LAST	d									
	PART II Other significant and dis-										
DICAL	PART II. Other eignificant condition	a contributing to a	eeth but not	reeulting ii	n the underlying	ceuse given in	Part I. 24a	PERFORE		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
							1	YES 2	□ NO		OF DEATH?
M	-										1 TYES 2 NO
ž	DID TOBACCO USE CONT	RIBUTE TO CAU	SE OF DEA	TH YE	S NO	UNCERTAIL	N 🗆				
8 1	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA		H (Check only one)						
ĮS I	1 TES AND	1 Inpatient 2 🗆 I	ER/Outpatient 3		OTHER: 4 Nursing Home	5 Residence	6 Other (Spe	ecify)			
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF IN (Month, Day		28b. TIME INJU	OF 26c. INJU	JRY AT RK?	26d. DESCRIE	E HOW IN	JURY OCC	CURED	
B	1 Natural 5 Pending 2 Accident Investigation					ES 2 NO					
1 280 PLACE DE INJURY — At home form effect factors effect.							loute Number,				
#	4 Nomicide determined		(//				City or los	wii, State)			
7	29a. CERTIFIER CERTIFYING PHYSI	CIAN: To the best of m	y knowledge, de	eth occurre	d at the time data	and place, and due	to the cause(s)	and man	ner ee elel	ad	
\$											and manner as stated.
	2 MEDICAL EXAMINE			_			,				The state of the s
B	1 2							7		-	
BE COMPLETED	290. SANATURE AND TITLE OF CONTINUES	MO				29c. LICENSE NUI	WBER		29d. DATI	ESIGNE	(Month, Day, Year)
	290. SUNATURE AND TITLE OF CONTINUES	CM				35 3	MBER 98		29d. DAT	IGNE	(Month, Day, Year)
TO BE CO	1 2	CM				1)35 3	98		29d. DATI	IGNED 171	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WN	COMPLETED CAUSE	OF DEATH (ITE		Print) KIWETO	1)35 3	SUIFE!	۱, د	29d. DATI	I HU	(Morith, Day, Year) H VSTBR, HUS
	290. SUNATURE AND TITLE OF CONTINUES	CM	OF DEATH (ITE			1)35 3	98	١, د	29d. DATI	17/	(Morith, Day, Year) H VSTER, HUS



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TO ITTREPAIRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HORPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR Certif					MENTA					
1	1. DECEDENT'S NAME (First, Middle, Last) EVENDELEA	WITKAD)S	ks	IOAII	_ 01	DLAI		2. DATE MONT		" 199L	YEAR	TIME OF DEATH	Н
0	4. SOCIAL SECURITY NUMBER 215–22–8250	5. SEX 8. AGE	(In yrs. lest birthday) YRS.	IF UNDER	DAYS	IF UNDER 2	MIN.	7. DATE	0f BHATH 16, 191	0 E	Country)	ACE (State of For	reign
TOR	9a. FACILITY NAME (If not institution, give at 10 BELHAVEN DRIVE RESIDENCE OF DECEMENT	treet and number)		9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUN					9c. COUNT	TY OF DEAT	ТН	
DIRECTOR	10a. STATE 10b. COUNT MARYLAND BALTIM		10c. CIT	c. CITY, TOWN OR LOCATION								Od. INSIDE CITY LIMITS? YES 2 X	
FUNERAL	100. STREET AND NUMBER 10 BELHAVEN DRIVE				101. ZIP CODE 10g. CITIZ 21236 USA						EN OF WHA	AT COUNTRY?	
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	- 1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RAC					I4. RACE — Black, V Specify:	- American India White, etc.	n,	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of life. Do NOT u	work done se retired.)	CCUPATIO during mo	ON st of working	1		. KIND OF BU		STRY	*****	
	10 17. FATHER'S NAME (First, Middle, Last) HARRY H. YINGLING	HOUSEWIFE					HOUSEKEEPING NAME (First, Middle, Maiden Surname)						
TO BE	HARRY H. YINGLING 198. INFORMANT'S NAME (Type/Print) 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES L. HENDRICKS, JR. 10 BELHAVEN DRIVE BALTIMORE, MARYLAND 21236												
	204, METHOD OF DISPOSITION VX. Burtel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State 20th care	D. PLACE AND DATE	OF DISPOS	ITION /Na	me of		OAT	E 20c. LO	CATION — CI			
	21, SIGNATURE OF FUNERAL SERVICE LIC	Inc.	LAS	SSAHN	FUNER	AL H	OME,			2122	6		
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiec or respiratory erreat, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO FOR AS A COMSEQUENCE DA.												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury												
CERTI	that initiated events resulting in deeth) LAST	d									/	<u> </u>	
MEDICAL	PART II. Other eignificent condition	e contributing to deeth b	out not resulting	in the un	nderlying	g csuse gl	ven in i	Pert I.	24a, WAS AN PERFOR 1 YES 2	MED?	AN CC OI	ERE AUTOPSY FIN MILABLE PRIOR T OMPLETION DF CO F DEATH?	TO AUSE
PHYSICIAN:	25. WAS CASE RESERRED TO MEDICAL				28. PL	ACE OF DE	ATH (Cho	ock only on	ng)				
IYSIC	1 WYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out			R: sing Hom	5 DRes							
ВУ	1 Hatural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)		M	1 🗆 1	RK? (ES 2 🗍	NO		CRIBE HOW I				
ETED	3 Suicide 6 Could not be destimined	28s. PLACE OF INJURY building, atc. (Spe-	city)					City	ATION (Street a or Town, State)			te Number,	
COMPLET		CIAN: To the best of my know R: Dn the basis of examination										nd manner as str	rted.
TO BE	299. SIGNATURE AND TITLE OF CERTIFIED	Depute Medica	PENNIN	0		29c. LICEN	ISE NUM	-		29d. DATE	SIGNED (M	onth, Day, Year)	

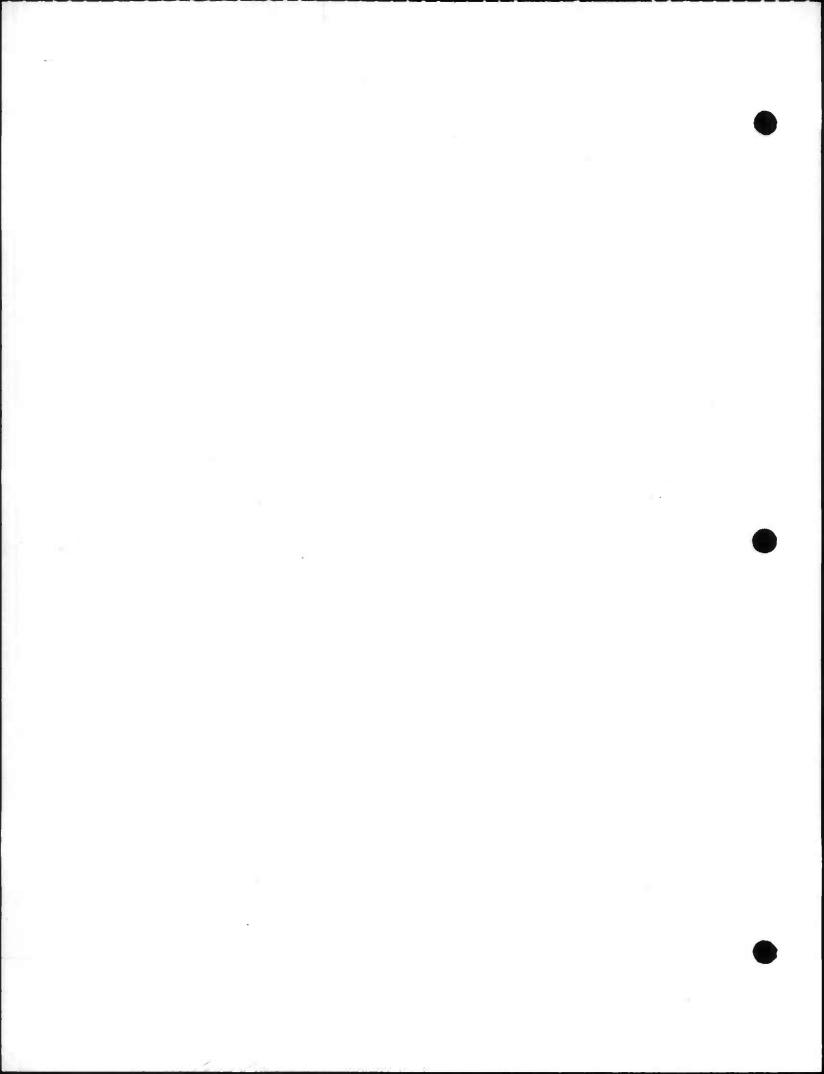
and think approximately

10 146. WA PLANT

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

) THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNEAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, should	the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
2	THE	be filed	IMPO	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DE	EPARTMENT OF	HEALTH AND N	NENTAL HYGIEN						
The state of	1. DECEDENT'S NAME (First, Middle, Lest) DOROTHY	ZIMNOCH			2. DATE OF DEATH		3. TIME OF DEATH 11:20 M				
	15-22-9172	5. SEX	Annual Labor		7. DATE OF BIRTH (Month, Day, Year) 7 — 4 — 1		ATHPLACE (State or Foreign				
TOR	9a. FACILITY NAME (If not institution, give street 3 LISA COURT RESIDENCE OF DECEDENT	it and number)	200	SEDALE	ATH	BALTO.					
FUNERAL DIRECTOR		LTIMORE 10	ROSEDAL			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
NERAL	100. STREET AND NUMBER 2 3 LISA COUR 11. MARITAL STATUS			21237	7 USA						
BY	1 Never Married 2 Married 3 XWidowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	If yes,	ECENDENT OF HISPANI Appecify Cuban, Maxican ES 2 NO Specify:	HISPANIC ORIGIN? (Specify Yas or No — HISPANIC ORIGIN? (Specify: Specify: WHITE						
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) 1 1 YEARS	TION 16a. DECED (Give ki life. Do H O ME	16b. KIND OF BUS	SINESS/INDUSTRY							
BE CON	17. FATHER'S NAME (First, Middle, Lest) JOHN PETTY 16. MOTHER'S NAME (First, Middle, Meiden Surname) JESSIE LOUISE HAAS										
2	19a. INFORMANT'S NAME (Type/Print) MRS. DONNA FALKENSTEIN 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 LISA COURT BALTO. MD. 21237										
	20a METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	ST. ST		Name of CEMETER AND ADDRESS OF FACE	RY12-12	BALTO.	Town, State				
	Karles X-XX	suculii	KACZ	OROWSKI L DUNDALK	FUNERAL	BAL TO	MD. 21222				
	23. PART I. Enter the disesses, or corshock, or heart fellurs. Lie IMMEDIATE CAUSE (Final disesse or condition resulting in deeth)	plications that caused the deeth.	ad	enlone	as cerdlec or respi	ratory arrest,	Approximate interval Between Onset and Death				
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
A P	PART II. Other significent conditions	contributing to deeth but not resul	iting in the underly	ng ceuse given In P	Pert I. 24a. WAS AN PERFOR	MEQ?	4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRII		YES NO				1 YES 2 NO				
YSIC	EXAMINER?	OSPITAL:	OTHER:	me 5 Rasidence 6	Other (Specify)						
ВУ РН	27. MANNER OF DEATH 1 Naturel 5 Pending 2 Accident Investigation	(Month, Oay, Year)	M 1	YES 2 NO	26d. DEŞCRIBE HOW I						
ETED	3 Suicide 6 Could not be detarmined	26s. PLACE OF INJURY — At home, building, etc. (Specify)	26f. LOCATION (Street & City or Yown, State)	and Number or Run	al Route Number,						
COMPL		N: To the best of my knowledge, death of the basis of examination and/or investigation.					e(s) and manner as stated.				
TO BE	30. NAME AND AGORESS OF PERSON WHO	mD		29c. LICENSE NUME	25	▶ /2 ₁	50/140ins 00, 1901				
	W.B. Hanrels Tr. 31. DATE FILEO (Month, Day, Year)	MON MEMORIA 32. REGISTRAR'S SIGNATURE	1 Harr	ie, Bo	Himore	2/2	18				
	DEC 0 9 1994 Jul	Studen Real y					DHMH-16 Rev 1/89				



BE COMPLETED BY FUNERAL DIRECTOR

9

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	OR CHAIN PROPERTY TO THE LAW REQUIRES that the death certificate be executed withhers, hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not make a start of Health and Merial Hygiene prior to burial, cremation, or remoral.	them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF	TO THE MOSPITAL OR A ENTRY PAYSH TO THE FUNERAL DIRECTOR After this or the filed within 72 hours and coult, with the	IMPORTANT: If Item 28 is marked,
	177	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

27. MANNER OF DEATH

1 Natural

2 Accident

4 Homicide

									94	3	6593
1 - FOR STATE REGISTRAR		STATE OF M	ARYLAND	/ DEPART	MENT (OF DE	H AND	MENTAL HYGIEN REG. NO.	E		
1. OECEDENT'S NAME (First	, Middle, Last) EDR	GE K	< /	1186	=R.7	15		2. DATE OF DEATH MONTH DA	-	YEAR 94	3. TIME OF DEATH 5 / 8 P. M.
4. SOCIAL SECURITY NUMBER 218 20 1103	3 20 1103 1√2 M 2 □ F 85 YRS.				IF UNDER 1 Y	EAR IF UN AYS HOUR	DER 24 HRS. S MIN.	7. DATE OF BIRTH (Month, Day, Year) August 31, 1909 Wash., D.C			
9a. FACILITY NAME (If not institution, give alrest and number) Laurel Regional Hospital RESIDENCE OF DECEDENT						own on Loc aurel	ATION OF D	EATH		NTY OF DE	eorge
Maryland	Total on Cocation								10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
100. STREET AND NUMBER 200 Ft. Meade Road #903						101. ZIP CODE 10g. CITIZEN C U.S.A					HAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES ZYONO IF YES, GIVE WAR OR DATES					13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexicen, Puarto Rican, etc.) 1 YES 2 MO Specify: White					White, etc.	
	EDENT'S EDUC y highest grade 0-12)			(Give kind of we life. Do NOT use	CEDENT'S USUAL OCCUPATION We kind of work done during most of working Do NOT use retired.) U.S. GOVERNMENT						
17. FATHER'S NAME (First, M George Will	,	lbertie				18. M		AME (First, Middle, Meiden aret Durrov			
190. INFORMANT'S NAME (nia A		Route Number, City or Town Severn,			144
20a. METHOD OF DISPOSIT 1	on 3 🗆 Remo	oval from State		EANDDATEO						City or Tow	vn, State e, Md.
21. SIGNATURE OF FUNERA	××	Kgr			22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. 313 Talbott Ave. Laurel, Md. 20707						
shock, or h	3. PART I. Enter the dispases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, shock, or heart tailure. List only one pause on each line. Approximate interval Between Onset and Death lisease or condition										

Dulmoug resulting in death) Minules DUE TO (OR AS A CONSEQUENCE OF): ecurrent Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): It any, leading to immediate cause. Enter UNDERLYING 5 chemic CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aigniticant conditions contributing 24a. WAS AN AUTOPSY PERFORMED?

DID TOBACCO USE CONTRIBUTE TO CAUSÉ OF DEATH YES

1 - YES 2 - NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO

NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO

26. PLACE OF DEATH (Check only one) HOSPUTAL OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Inpatient 2 ER/Outpatient

28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 1 YES 28e. PLACE OF INJURY -- building, etc. (Specify)

28d. OESCRIBE HOW INJURY OCCURED 2 NO

29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN

2 MEDICAL EXAMINER 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

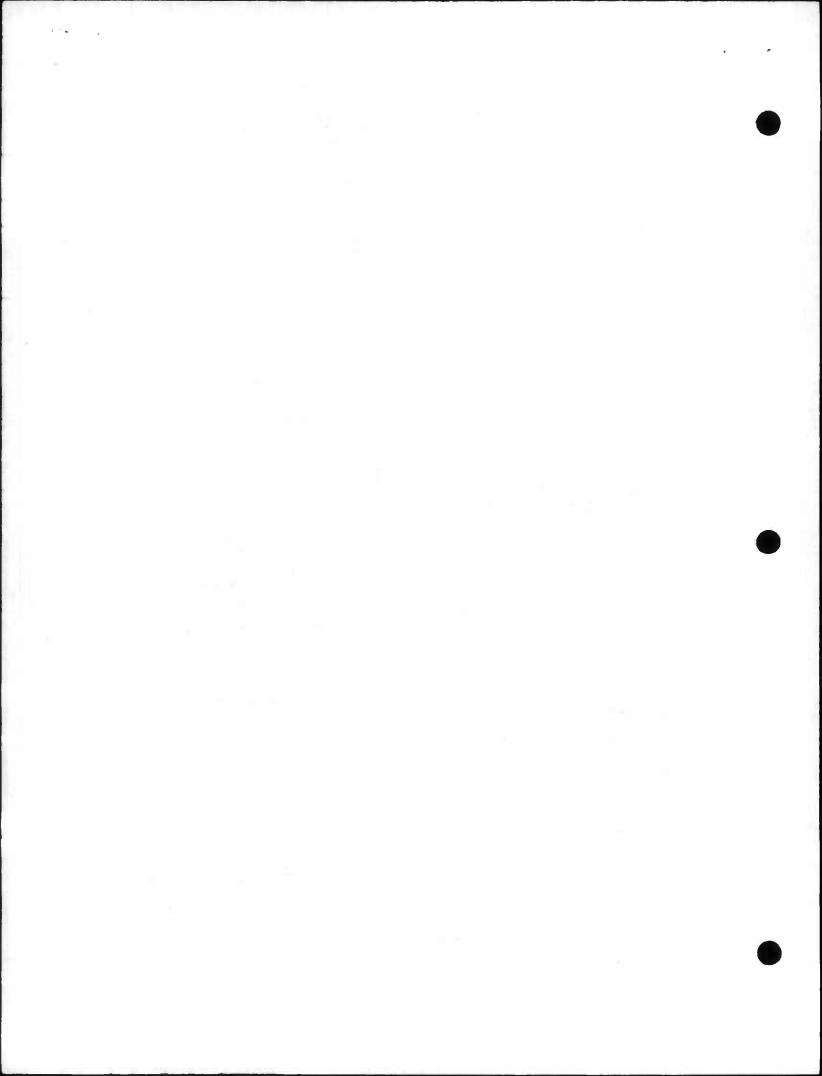
			7
30. NAME AND AODRESS OF P	ERSON WHO COMPLETED CAUSE OF I	DEATH (ITEM 27) (Type /	Print

Investigation

29d, DATE SIGNED (Month, Day, Year) 0

DINI 32 TEGISTAM





DIVISION OF VITAL RECORDS, P.O. BOX 68760,

after death. Page 6 may be retained by the hospital or attending physician.

y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	r this certificate has been signed by the attending physician and completely fi	The same that the same and the same that the same and the same that the
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH							
		Waldorf A				December 9,1994 9:00 A.					
	212 10 4404		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Cour	HPLACE (State or Foreign otry)			
		M 2 □ F 8	8 YRS.			09 30 06		land			
œ	90. FACILITY NAME (If not institution, give street 413 GReenland Beac				OR LOCATION OF DEA	ATH	9c. COUNTY OF				
DIRECTOR	RESIDENCE OF DECEDENT	en Road		scorie	Creek		Anne Ar	undel			
Æ	10e. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCA	TION			10d. INSIDE CITY			
	Md. Anne Ari	undel	Sto	ney Cre	ek			LIMITS? 1 YES 2 NO			
AL	10e. STREET AND NUMBER			10	H. ZIP CODE		tog. CITIZEN OF	WHAT COUNTRY?			
FUNERAL	413 Greenland Be	each Road			21226		USA				
à		WAS DECEDENT EVER I	N U.S. ARMED		CENDENT OF HISPANI pecify Cuban, Mexican	C ORIGIN? (Specify Yes	or No — 14. RAG	CE — American Indian, ck, While, etc.			
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR E			S 2 NO Specify:		Spe	city:			
	15. DECEDENT'S EDUCATION	ON .	44. 0505054710	1		I man man man man man man man man man man	Whi	te			
TE	(Specify only highest grade com	pleted)	(Give kind of w ille, Do NOT use	ork done during m	ost of working	166. KIND OF BUS	SINESS/INDUSTRY				
PLE	Elementary/Secondary (0-12) Co	oliege (1-4 or 5 +)	Machi			Facto	ry				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Placifi	IIISC	16. MOTHER'S NAM	NE (First, Middle, Maiden	Surname)				
	Harry Connor And	Person				ay Shoema					
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		oute Number, City or Tow					
2	Dorothy H.Anders	son				d. Balto.		26			
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal		. PLACE AND DATEO	F DISPOSITION (A	lame of	DATE 20c. LO	CATION - City or 1				
	4 Donation 5 Dother (Specify)		reen Mou		atory 12	-12-94 Ba.	2-94 Balto.,Md.				
	21. SIGNATURE OF FUNERAL SERVICE LICENS	EE		22. NAME AND ADDRÉSS OF FACILITY Charles S. Zeiler & Son Inc.							
	Charles I). Jelle	~	6224	res s. Ze	ller & Som Ave. Balto	n Inc.				
	23. PART I. Enter the diseases, or com	plicetions that ceuse	d the deeth. Do no	ot enter tha m	ode of dying, such	es cerdiac or reapi	retory errest,	Approximata			
	ehock, or heart failure. List IMMEDIATE CAUSE (Final	only ona ceuse on a	ach line.	1		A		Interval Between Onset and Death			
	diseese or condition	De.	STAN	lem	NARER	7					
	resulting in death) a	DUE TO (OR AS	A CONSEQUENCE OF	1	2001	. 1	1 1/1				
z		Brown	muc	CAVY	P. LA YMA	ng (hrny	uxlotax	roll			
은 I	Sequantielly list conditions, if any, leading to immediate	DUE TO (OF AS	ONSEQUENCE OF	: 1	7) 0.0.		/ //				
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	Sym	comes		/	V		1			
	that initieted evente resulting in death) LAST	DUE TOYOH AS	A CONSEQUENCE OF):							
5	_ A_	mu	Nex								
	PART II. Other eignificent conditione co	ontributing to deeth i	out not reaulting li	the underlyin	ng cause given in F	art I. 24e. WAS AN		b. WERE AUTOPSY FINDINGS			
MEDICAL	Lunchmannsk	Mr. NT	1,200	new	us Ther	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
Ä		,	0	1	y			OF DEATH? 1 YES 2 NO			
_	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	OF DEATH YE	S NO [UNCERTAIN						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only one							
/SI		OSPITAL: Inpatient 2 ER/Out	petient 3 DOA	OTHER: 4 Nursing Hor	me 5 - Residence 8	Other (Specify)					
F	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME		JURY AT ORK?	28d. DEŞCRIBE HOW I	NJURY OCCURED				
ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO						
ED	3 Suicide 8 Could not be	28e. PLACE OF INJUR' building, atc. (Spe	 At home, lerm, st city) 	reet, lectory, offi	ce	281. LOCATION (Street of City or Town, State)		Route Number,			
ETE	4 Homicide determined										
7	29e. CERTIFIER (Check only to CERTIFYING PHYSICIAN	: To the beat of my know	rledge, death occurre	d at the time, dat	e and place, and due t	o the cause(a) and man	nner ee stated,				
COMPLET	one) 2 MEDICAL EXAMINER: O	n lhe basis of examination	on and/or investigation	, in my opinion,	death occured at the t	ime, data and placa, an	d due to the ceuse	(a) and manner as stated,			
0 1		NWIN			29c. LICENSE NUM	BER	29d. DATE SIGNE	D (Month, Day, Year)			
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	A					D 12/10/94				
O BE	29b. SIGNATURE AND TITLE OF CERTIFIER	who	MA		D880	(12/10	194			
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CHOSE OF DI	EATH (ITEM 27) (Type	Print)	D880		12/18	194			
	30. NAME AND ADDRESS OF PERSON WHO EC	OMPLETED CHOSE OF DE	MA) EATH (ITEM 27) (Types THEN B	Print) UVNIC	MD 880	21061	12/18	194			
	Muk MM &	OMPLETED CHOSE OF DE	Flen B	Print) UVNje	MD 2	21061	12/18	794			



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BALTIMORE, MARYLAND

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITA
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IMPORTANT: I

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ATTE	afte	28
) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be instanted by the houseaut.) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be described for a filled within 72 hours after death with the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal.	APORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 7
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY AHRON DEC. 8, 1994 10:12 AM M BEN-AVRAHAM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 217-29-2822 13 12/31/1980 1X M 2 | F ISRAEL 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE BALTIMORE 1 YES 2 XNO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 6610 SANZO RD. 21209 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE - American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced WHITE **etto** 18a. DECEDENT'S USUAL OCCUPATION

**Cham kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT - SCHOL COMPL 8 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Sur SANDRA SARA REST EZRA VANYA BEN-AVRAHAM BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS.SANDRA SARA BEN-AVRAHAM 6610 SANZO RD. BALTIMORE, MD 20a METHOD OF DISPOSITION
1 Device 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cemetery, crematory or other place)
SHEARITH ISRAEL 4 Donation 5 Other (Specify) 12/8/1994 BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, Dr heart feliure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death Polymorphic Ventricular Tachycardia Due To (OR AS A CONSEQUENCE OF): disease or condition_ resulting in death) Idepathic Cardionypathy CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese Dr Injury DUE TO (OR AS A CONSEQUENCE OF that initieted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IX UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 ☐ Inputient 2 ER/Outputient 3 ☐ DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 12/8/94 1 YES Z NO Collapsed after getting BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(s) and manner as stated. 296. SHOMATURE THIS TIPLE OF CERTIFIER 29¢. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE DAGE, D41316 Frewerer MD 2 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John H. Lawrence Ross 844/ 720 Rutland Ave Johns Hop

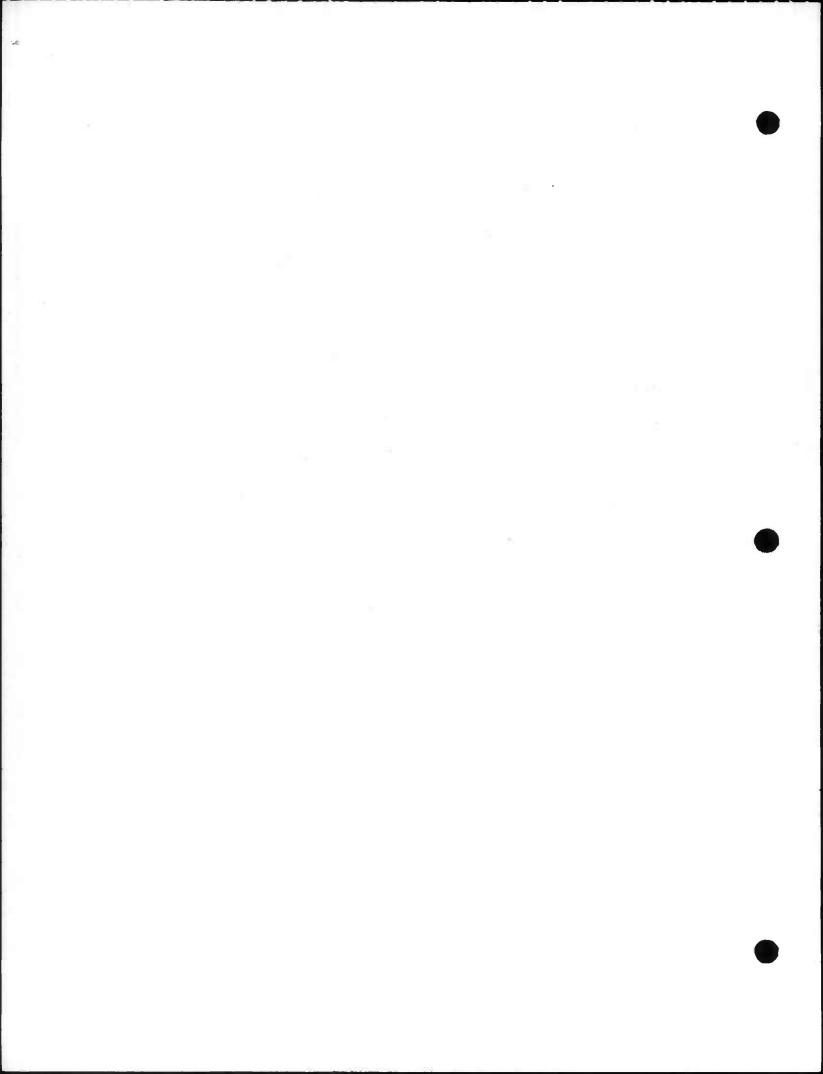
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MA					EALTH AND DEATH	MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) JEAN			BER	MAN			MON	EC. 8,	1994	YEAR	3. TIME OF DEATH 4:30 AM M
	4. SOCIAL SECURITY NUMBER 212-42-2967	1 □ M 2 💢 F	AGE (In yrs. les	ot birthday) 7 YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.		E OF BIRTH	1917	COUNTY COUNTY	PLACE (State or Foreign
TOR	99. FACILITY NAME (If not institution, give si 8511 STEVENSWOOD RESIDENCE OF DECEDENT		ri .				R LOCATION OF D	EATH		9c. COUNT		EATH BALTIMORE
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND	BALTIMOR	RE	10c. CIT	Y, TOWN O		IMORE					10d. INSIDE CITY LIMITS? 1 YES 2 A NO
FUNERAL	100. STREET AND NUMBER 8511 STEVENSWOOD	ROAD		101. ZIP CODE 21 244					10g. CITIZ	EN OF V	VHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT ET FORCES? 1 IF YES, GIVE WAR	YES 2 X	2 XNO If yes, specify Cuben, Mexice			en, Puerto Rican, etc.) Blac			4. RACE Black Speci	— American Indian, k, White, etc.	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	(Specify only highest grade completed)			16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					SINESS/INDU	STRY	
COMP	17. FATHER'S NAME (First, Middle, Last)	12 FATHER'S NAME (First, Middle, Last)			USEW.	IFE	16. MOTHER'S NA	ME (First		HOME Surname)	<u></u>	
8	ISAAC 190. INFORMANT'S NAME (Type/Print)	1.00		4000000	10:			ECCA		KAT	Z	
2	MRS. CAROLE GAIL	LURIE		3	SOU	TH F	OAD CHE		, N.J.	07930)	
	20e. METHOD OF DISPOSITION 1 Debute: 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LUBAWITZ NUSACH ARI (NER TAMID) 12-9-94 ROSEI								wn, State DALE, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ensee dev	ma	9		SOL	LEVINSOI REISTE	3 V.			rimc	ORE, MD 2121
	23. PART I. Enter the diseases, or of ehock, or heart fellure.	omplications that ca List only one cause	oused the de on each line	eth. Do r	not enter	the mo	ie of dying, auc	h aa ce	rdlec or reepli	retory arre	et,	Approximete Intervel Batween
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	TE CAUSE (Final or condition on the condition of the cond										
CERTIFICATION	Sequantielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in death) LAST											
Ϋ́	PART II. Other algolficent condition	e contributing to dec	eth but not r	resulting i	n the unc	derlylng	ceuee given in	Pert I.	24s. WAS AN PERFORM	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUS			S N		UNCERTAI	V 🗆				1 YES 2 NO
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	7.000 - 207	-	OTHER	:	5 G Residence	6 🗆 Oth	er (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJ (Month, Day, Y	URY bar)	28b. TIM	E OF URY M	26c. INJU WOI	RK?	28d. DE	SCRIBE HOW IN	JURY OCCU	RED	
TED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF IN building, etc.	JURY — At ho (Specify)	me, term, s	street, facto		2 2 10	281. LOCATION (Street and Number or Rural Floute Number, City or Town, State)				oute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINED											end menner ee stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year)								(Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITE	27) (Type,	Col	2	Ra	de	1154	on	- [MO-21137
	DEC1 2 1994	32. REGISTRAR'S	SIGNATURE									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral directior, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			ENTAL HYGIEN				
7	1. DECEDENT'S NAME (First, Middle, Lest) Ruby M. Blake					DATE OF DEATH		3. TIME OF DEATH 4 3:50 P	м	
9	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR ITHS DAYS	IF UNDER 24 HRS. 7	Month, Day, Year)	8. B	HATHPLACE (State or Foreign ountry) St Virginia		
FOR	96. FACILITY NAME (If not institution, give st Meridian Severna RESIDENCE OF DECEDENT	reet and number) Park Nursing	Home S	err, тоwn o	R LOCATION OF DEAT Park	OF DEATH 9c. COUNTY OF DEATH				
DIRECTOR	10a. STATE 10b. COUNTY	Arundel		WN OR LOCAT Burnie		10d. INSIDE CITY LIMITS? 1 YES 2 X NO	\exists			
FUNERAL	450 Quarterfield	Rd.			ZIP CODE			of what country? States		
ВҰ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, spe	ENDENT OF HISPANIC ocity Cuben, Mexican, I 2 NO Specify:	ORIGIN? (Specify Yes Puerto Rican, etc.)	RIGIN7 (Specify Yes or No— 14. RACE — American Indian, Black, White, etc.) Specify: White			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret HOMEMAKEY	done during mos ired.)	N st of working	Own He		USTRY		
BE COM	17. FATHER'S NAME (First, Middle, Lest) Warder West			Lydia Rh	(First, Middle, Malden			┪		
TO	Peggy A. Schwartz				nd Number or Aural Aou Rd., Sever			•		
	20e. METHOD OF DISPOSITION 1 [X] Buriel: 2 ☐ Cremetion 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	oval from State com	place and date of di etery, cremetory or other p ttle Kana	Na Mem	. Gar. 12	/15/94 F1		s, W.V.		
	· Dest of	2de		Kirkle 421 Ci	ey-Ruddic cain Hwy.	k Funeral , S.E. Gl	Home en Burr	nie, MD 2106	51	
	23. PART I. Enter the diseases, or c shock, or heart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Due to (or as a	the deeth. Do not each line.	Ara	de of dying, such a	he cardiac or reap	Iratory arrest,	Approximata interval Betwee Onset and De	en	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO JOH AS A	CONSEQUENCE OF):	sono	rmon	in	` 0	Pay		
AL CEF	PART II. Other significent conditions	a contributing to death be	ut not resulting in th	e underlying	cause given in Pa			24b. WERE AUTOPSY FINDING	GS	
MEDIC						PERFOR		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	Ē	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Output		HER:	ACE OF DEATH (Check					
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY		JRY AT 2	8d. DESCRIBE HOW I	NJURY OCCURE	D	٦	
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, atc. (Speci	— At home, farm, street	nome, farm, street, factory, office 281.			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED		CIAN: To the best of my knowledge. R: On the basis of examination						use(s) and manner as stated.		
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER	parte, 1	rD.		D297	67	29d. DATE SIG	NED (Month, Day Year)		
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	k,MD	81	118 B	tA 312	12. A	sadona, M	4	
	DEC 1 2 1994	the dedicate	Rules					011		

9.200 and 12.50 1888 5 1889

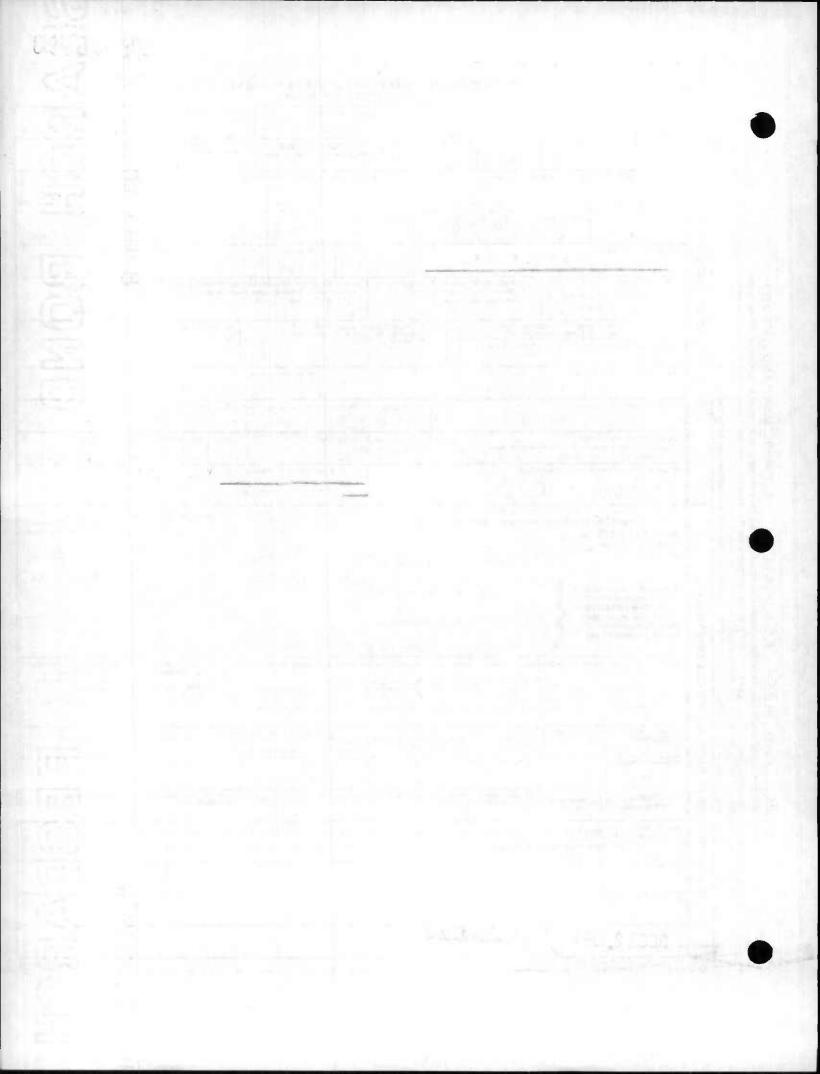
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within. Durs after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

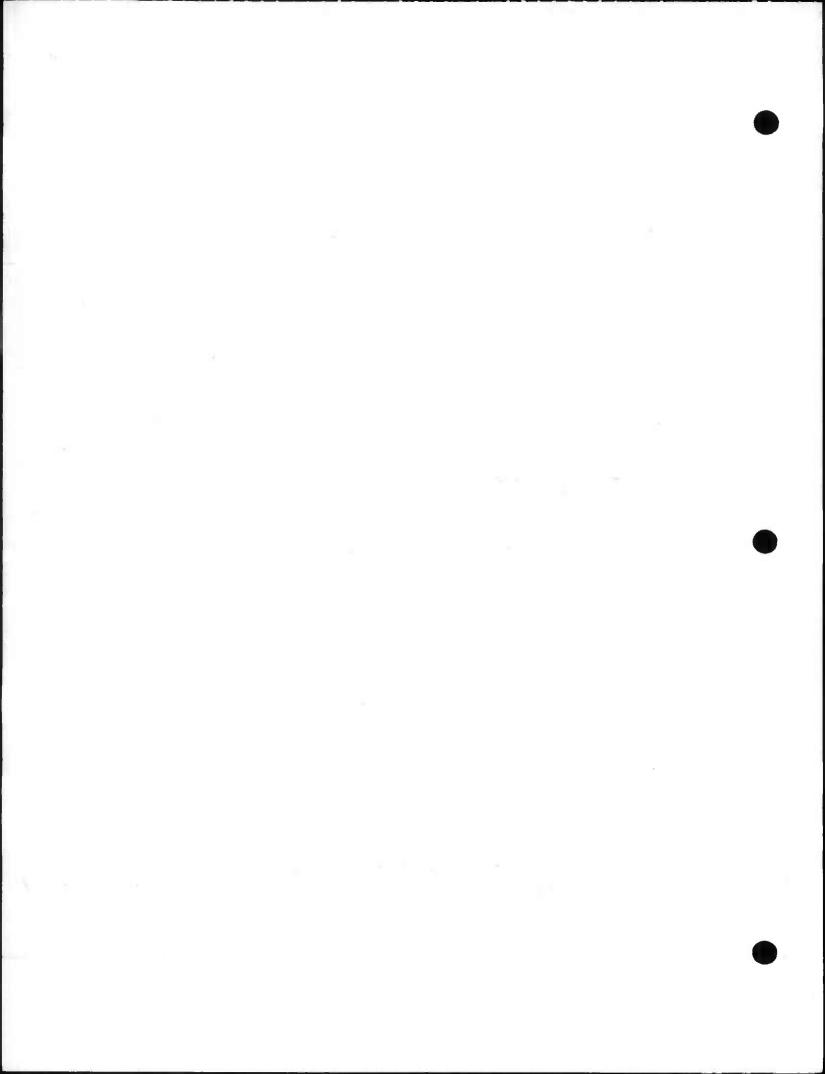
REGISTRAR		CENTIF	ICATE OF	DEATH	REG. NO.	11-	
1. DECEDENT'S NAME (First, Middle,	1 - 2 - 1	ie.			2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF		
4. SOCIAL SECURITY NUMBER 218-24-6315		AGE (In yrs. lest birthday) 68 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEB 14	100	IRTHPLACE (State or Foreign ountry) REDERICK, MD
Se. FACILITY NAME (If not inetitution,		6		OR LOCATION OF DE		9c. COUNTY	
RESIDENCE OF DECEDEN			TY, TOWN OR LOCA				10d. INSIDE CITY
100. STREET AND NUMBER	A ALL SOUTH ST			of. ZIP CODE		10g. CITIZEN	1 YES 2 □ NO OF WHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT E	YES 2 NO	If yes, s	21701 CENDENT OF HISPAN pecify, Cuban, Mexica s 2 NO Specifi	NIC ORIOIN? (Specify Yearn, Puerto Rican, atc.)	or No- 14, I	U.S.A. RACE — American Indian, Black, White, etc. Sociity: BLACK
3 Wildowed 4 Divorced 15. DECEDENT'S (Specify only highest	B EDUCATION	184. DECEDENT'S	USUAL OCCUPAT work done during rr se retired.)	ION	16b. KIND OF BUS	SINESS/INDUSTI	97
Specify only highest Elementary/Secondary (0-12) 5 TH 17. FATHER'S NAME (First, Middle, La	College (1-4 or 5+)		E REPA	IR	1 5 17 19	And Season	RT STORE
RAIMOND BO	WIE		4	PEAR	ME (First, Middle, Maiden LINE FREI	DERICK	
DOROTHY ROL		201	A WEST	SOUTH	ST FREDE	ERICK,	MD. 21701
20g. METHOD OF DISPOSITION 1 Densition 5 Other (Specify, 21. SIGNATURE OF FUNE NAL. SERVI		PAIRVIEW	CEM.	12	DEC 94 B		ICK, MD.
+ Say &	Follus		CARY	TO ROL	GLING GARY L. F LING FUNI ALL SAIN	TRAL H	OME MD. FREDERICE
23. PART I. Enter the disease shock, or heart fail iMMEDIATE CAUSE (Final disease or condition resulting in death)	s, or complications that clure. List only one cause	aused the dath. Do on each lina. The Rouse Rouse of the	l Fai	littl	h aa cardlac or reapi	ratory arrest,	Approximata interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a	R AS A CONSEQUENCE O	7	selero.	DÉS .		syan
		/)			Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
PART II. Other aignificant con	brehary	arley a	isla	e ————————————————————————————————————	1 □ YES 2		COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER'OF DEATH	HOSPITAL:	Similar Sale	OTHER:	PLACE OF DEATH (Ch			
	28a. DATE OF IN (Month, Day,		ME OF 28c. IN	JURY AT ORK? YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURE	0
a Davida	28e. PLACE OF II	NJURY — Al home, farm, (Specfly)	street, factory, offi	ce	281. LOCATION (Street a City or Town, State)		ural Route Number,
E onel	PHYSICIAN: To the best of my						use(s) and manner as stated.
296. SIGNATURE AND TITLE OF CEN	O Tanus) h		29c, UCENSE NUI	WBER	29d. DATE SIG	INED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSO		-1	s, Print)				
31. DEC1 2 1994	July Deutstan	GN TUTE					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

mysician.	nd completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
M arrending	use as the		
the hospital of	detached for		once.
retained by	5 should be		notified at
Je o may oe	irector, page		must be
Deall, rai	he funeral d	ral.	i examine
HOURS ATE	filled in by t	on, or removal.	he medica
allen within	I completely	e prior to burial, cremation	ic event, t
ICAIE DE EXEL	ian a	2	er traumat
neath certif	e attending	Mental Hygiene prio	ury, or oth
ulies tridi tri	s certificate has been signed by the attending physic	State Dept. of Health and Mental Hyg	i, or item 23 shows any injury, or other traumatic event, the medical examiner must be not
hai wa aiii	nte has been	ate Dept. of	em 23 sho
E	this certifica	with the	rked, or it
AL LENDING	DIRECTOR: After	irs after death	л 28 Іѕ та
un dell'ent	FUNERAL DIR	within 72 hour	TANT: If item 28 is marked

	1 - FOR STATE REGISTRAR	E OF MARYLAND /		MENT OF H			HYGIENE REG. NO.			
- 1	1. DECEDENT'S NAME (First, Middle, Last) Enid Lucille Bu	raaraf				2. DATE OF MONTH	DEATH		EAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	rggraf	of historias)	F UNDER 1 YEAR	IF UNDER 24 HRS.	Dec.	1		94	12:05 a M
	174-16-3119 1 I M	2 X € 77	YRS.	ONTHS DAYS	HOURS MIN.	May	Day, Year)	1917 I	Penn	sylvania
œ	9a. FACILITY NAME (If not institution, give street and n	,			R LOCATION OF DE	EATH		9c. COUNTY		
DIRECTOR	6825 Campfield Road	Apt. 8-H		Baltimo				Balti	mor	e
FE	10e. STATE 10b. COUNTY			TOWN OR LOCAT	ION					10d. INSIDE CITY LIMITS?
	Maryland Baltimore	9	Balt	imore	ZIP CODE			40 0/7/20		1 YES 2 X NO
FUNERAL	6825 Campfield Road	Ant 8-H			1207					tates
S	11. MARITAL STATUS 12. WAS	DECEDENT EVER IN U.S. AR		13. WAS DEC	ENDENT OF HISPAN				RACE	- American Indian,
BY F		CES? 1 TYES 2 XX N ES, GIVE WAR OR DATES	40		cify Cubsn, Mexica 2 X NO Specify		en, etc.)	i	Specify	White, etc.
	15. DECEDENT'S EDUCATION	100 DE	CEDENT'S US	UAL OCCUPATIO	A1	1401 11			-	White
	(Specify only highest grade completed) (G	ive kind of work. Do NOT use r	k done during mos	n et of working	16b. K	IND OF BUS	NESS/INDUS	TRY	
P		Ho	memake	er		Ov	vn Hor	oe		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA		idle, Meiden S	iumeme)		
B	Harold Koontz		_		Ruth Li	0				
2	Rev. Donald L. Burggi				nd Number or Rural I					21212
	20a. METHOD OF DISPOSITION			DISPOSITION (Ne	venue B	DATE		ATION - CIT		
	1 Buriel 2 Cremetion 3 M Removal from 4 Donetion 5 Other (Specify)	State cemetery, cre	matory or other			12/15				ip, PA
	21. SIGNATURE OF FUNERAL SERVICE LICENSES	74-	WOODL C	22. NAME AN	D ADDRESS OF FA	CILITY				др, лл
	> Ohm T. 61			Mitch 6500 v	ell-Wied ork Road	lefeld	Home M	, Inc	212	12
	23. PART I. Enter the dleassae, or complicat	tions thet ceused the da	eth. Do not							Approximate
	shock, or haart failure. List only IMMEDIATE CAUSE (Final	one ceuea on asch ilna	L.	^	۸ .					Interval Between Onset and Desth
	disease or condition recuiting in death)	Metopol	Te C	alan-	rector	Cole	cint	ma		
		DUE TO (OR AS A CONSEC	OUENCE OF):							
ON	Sequentially list conditione, b.	DUE TO (OR AS A CONSEC	OUENCE OF:							
CAT	if any, leading to immediate cause. Enter UNDERLYING		,							į
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEC	DUENCE OF):							
CERTIFICATION	resulting in death) LAST									
	PART ii. Other significant conditions contrib	outing to death but not r	asulting in	tha underlying	cause given in	Part I. 2	ta. WAS AN A			WERE AUTOPSY FINDINGS
MEDICAL						t	PERFORI		(AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME										YES 2 NO
ä	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF DEA	TH YES		UNCERTAIN	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSP			(Check only one)						
14S		tilent 2 ER/Outpatient 3 OATE OF INJURY	DOA 4		5 Realdence					
	1) Netural 5 Pending	(Month, Day, Year)	INJUR		PK?	280. DESCH	INBE HOW IN	JURY OCCUP	RED	
) BY	2 Accident Investigation 3 Suicide 8 Could not be	PLACE OF INJURY — At ho	me, farm, stre					nd Number or	Rural Ro	ute Number,
COMPLETED	4 Homicide datarmined	building, atc. (Specify)				City or	Town, State)			
ä	29e. CERTIFIER (Check only	he best of my knowledge, de	ath occurred a	at the time, data	and place, and due	to the cause	(e) and man	er ee stated.		
NO.	one) 2 MEDICAL EXAMINER: On the								euse(e)	end manner ee stated,
W.	29b. SIGNATURE AND TITLE OF CERPTIER	n A	treuk	who I	29c. LICENSE NUN	MBER		29d. DATE S	IGNED (Month, Day, Year)
Ì	Mount for	Mon	- (U	1107	930		> /k	رسا	12,1994
	MARYIN J. FELDMAN	M.D. 3015			407	BALT	TO. M	D. 2	120	2
		REGISTRAR'S DIGNATURE								



BALTIMORE, MARYLAND 21215-0020	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	INFECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	1
BOX 68760	icate be executed with	ohysician and comple e prior to burial, cre	***
P.O.	th certif	Hvaien	44
IVISION OF VITAL RECORDS, P.O. BOX 68760	requires that the deat	WRECTOR: After this certificate has been signed by the attending physician and completely filled in by the famous after death with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal.	
ITAL	V: The faw	State Deof.	00
OF V	HYSICIA	his certifi	
NOI	NDING PI	t death w	
IVIS	R ATTE	IRECTOR	

BE

2

31. DATE FILEO (Month, Day,

DEC1 2 1994

AME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF DEATN 4500 FRANCES BRAGG 12 8. AGE (In yrs. lest birthday) . SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8-8-190 a. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 8 228- 22-6692 85 DAYS HOURS 1 M 2 DF 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH RKIN CHASE NSG & RESTORATIVE C P.G. DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Urginiainenbur brick 1 YES 2 1 NO FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3944 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian. Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BLACK BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Manag 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden St. Boswell fersor Joh BE 0 19m. INFORMANT'S NAME (Type/Print) 19h MAILING ADDRESS /Str 2 91 brook 20706 20s. METHOD OF DISPOSITION

1 Souriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of ☐ Donation 5 ☐ Other (Specify) ot. Church Comm 12-7/L 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY S.P. Jone + Home Dell Broad 57. VA-23944 Kenbridse 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory arre Approximate shock, or heart failure. List only one cause on sech line. Interval Between Onest and Death IMMEDIATE CAUSE (Final evosis diseese or condition_ DOYS resulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to Immediate cause. Enter UNDERLYING cumanatosis CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF that initiated avents resulting in death) LAST Ada. Corce tr PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY MEDICAL 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL . OTHER: 1 YES 2 PHO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 5 Pending Investigation 1 YES 2 NO BY 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be ETED 4 Homicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and r COMPL (Check only one) 2 MEDICAL EXAMPLER: On the basis of examination and/or investigation, in my opinion, death occurred at the time,

570

29c. LICENSE NUMBER

AMMAPOLIS

26

128

DNMN-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

(Arhon

She is the the parties and the second and the secon MICE As we make the bear of the

9c. COUNTY OF DEATH

USA

Prince George

10g, CITIZEN OF WHAT COUNTRY?

White

3. TIME OF DEATH

OPM

8. BIRTHPLACE (State or Foreign

Washington, DC

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 1 NO

Approximate interval Between

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

12/9/94

COMPLETION OF CAUSE

Onset and Death

30

2. DATE OF DEATH

BUTMS John 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH Dec 19 1923 1 M 2 D F DAYS 578 - 26 - 4578 70 YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Laurel Regional Hospital Laurel 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Howard Laurel регтіг FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 20723 9854 Whiskey Run 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED MARYLAND 21215-0020 FORCES? 1 YES 2 2 NO 1 X Never Merried 2 Merried BΥ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12 Jeweler Jewelery Shop once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE Martin Burns Mary Berry 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 9902 Mayfield Drive, Bethesda, Maryland 20817 James Burns BALTIMORE. pe 20e. METHOO OF DISPOSITION
1 XI Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION — City or Town, State must the funeral director, tary, crematory or other place)

t. Olivet Cemetery 4 Donetion 5 Other (Specify) 12/12 Washington, D.C. medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707 completely filled in by the rial. cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, euch as cardiec or respiratory errest, shock, or negrifications. List only one cause on each line. IMMEDIATE CAUSE (Finei the disease or condition_ OUE TO (OR AS A CONSCOUENCE OF): resulting in deeth) requires that the death certificate be executed within other traumatic event, P.O. BOX 68760. burial. Cardiomagapothy
DUE TO (OR AS A CONSEQUENCE OF): and CERTIFICATION Sequentially list conditions, Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 Mental IVISION OF VITAL RECORDS, PART II. Other significent conditione contributing to deeth but not reculting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the shows any 1 TYES 2 T NO has been e Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: OR ATTENDING PHYSICIAN: The law item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h h the State [d, or item HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 YNO 1 Inpatient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH this c. 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 1 YES 2 NO death y DIRECTOR: After the hours after death ВY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 28 4 🗌 Homicide 29e. CERTIFIER

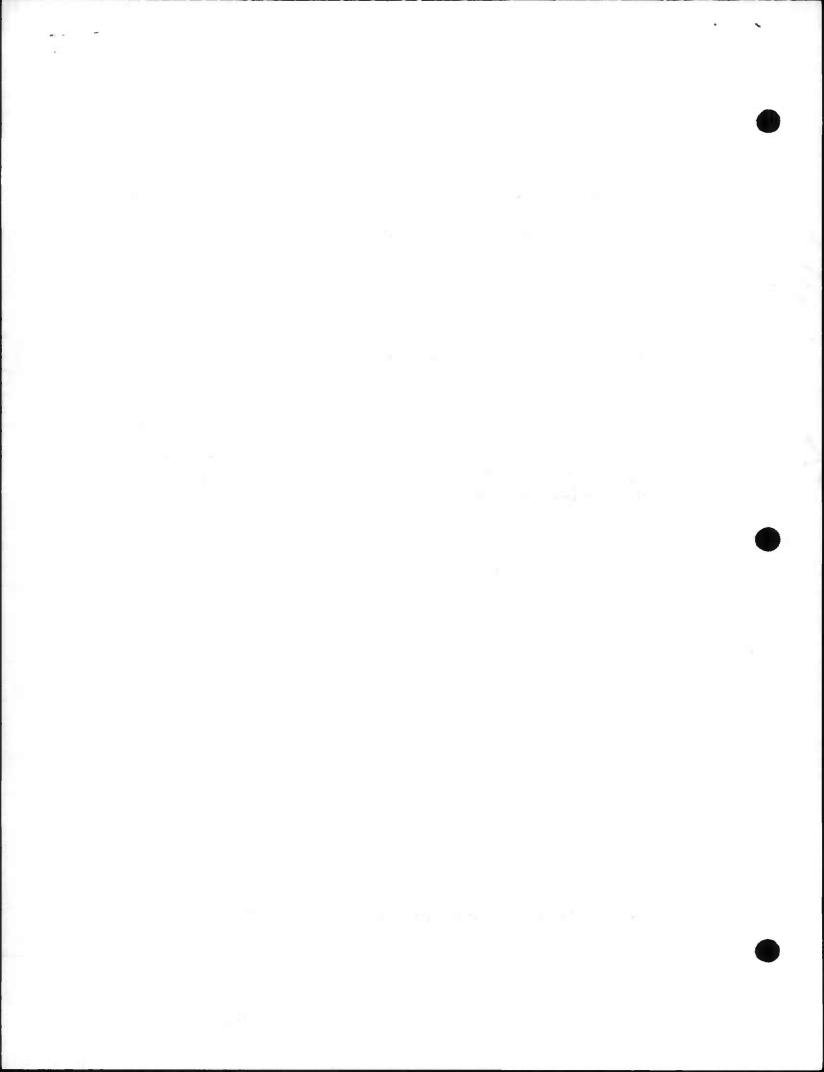
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. TO THE HOSE TO TO THE BE FILED WITHIN 72 ho 2 MEDICAL EXAMINER: On the besie of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David D22389 2 July Wiember 1406 7900 Wisconsin Avenue. #406, Bethesda, Maryland 20814

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 687604

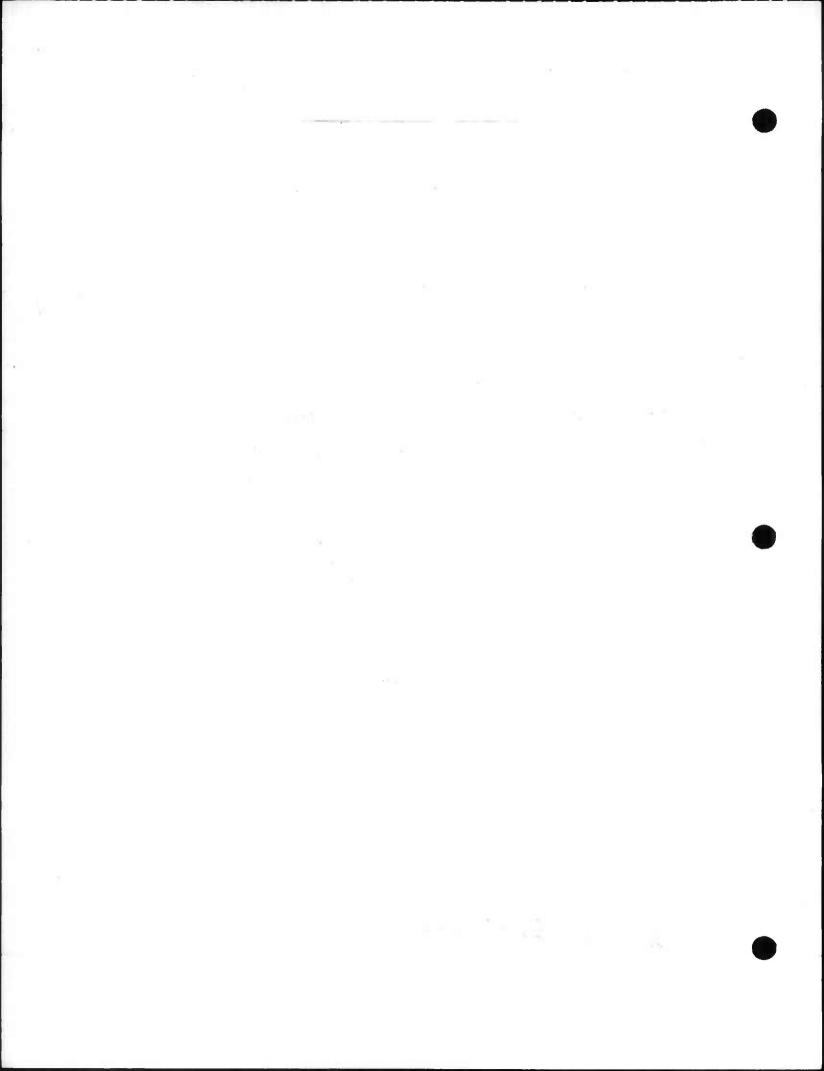
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

REGISTRAR		CERTIFI	CATE C	F DEATH	REG.	NO.		
1. DECEDENT'S NAME (First, Middle, Last)	Margaret GERIR	UDE CLABAUG	GH Clawbay	ap-	2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH
					Decembe	er 9,1	994	М
217-07-2172	□ M 2 🂢 F	(In yrs. last birthday) 77 YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, You Sept 23	1917	8. BIRTI Count	HPLACE (State or Foreign fry) Maryland
9a. FACILITY NAME (If not institution, give street Greater Baltimore		r.	9b. CITY, TOW	N OR LOCATION OF D	EATH		unty of c altir	
10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LO	CATION				10d. INSIDE CITY
Maryland	Baltimore			Par	<u>kvil</u> le	1		LIMITS? 1 YES 2 X NO
2507	Taylor Ave				21234			States
11. MARITAL STATUS 1 Never Merried 2 X Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D	2 X NO	If yes.	DECENDENT OF HISPA , specify Cuban, Maxica YES 2 X NO Specif	in, Puerlo Rican, etc.		14. RACI Blac Spec	E — American Indian, k, White, atc. White
15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondery (0-12)	ION npleted) College (1-4 or 5+)	life. Do NOT use	rock done during	ATION most of working	16b, KIND OF	BUSINESS/IN	DUSTRY	
17. FATHER'S NAME (First, Middle, Last) Charles	N. Jager				ME (First, Middle, Mail		t	
198. INFORMANT'S NAME (Type/Prim) George C. Clabaug	h			et and Number or Aural Ave. Bi	Aoute Number, City or altimore,			21234
20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		PLACE AND DATE Of the land	Memori	al 12/13	2/94 B	altime	ore	Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME	AND ADDRESS OF FA	Leona	rd J.	Ruck	i, Inc.
23. PART I. Entar tha diseases, br com shock, or hasrt fallura. List IMMEDIATE CAUSE (Final	plications that cause tonly one cause on a	d tha death. Do nach lina.						Approximate Interval Batween Onset and Death
disease or condition resulting in death)	Accel DUE TO (OR AS A	5 my	v col	del comey &	fore	le le		insucet,
Sequentially list conditions, b	AU DUE TO (OR AS A	CONSEQUENCE OF	elm	orang &	done			
It sny, laeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury		CONSEQUENCE OF						
that initiated events resulting in death) LAST			,					
PART II. Other significant conditions of	ontributing to death b				PER	AN AUTOPSY ORMED?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
mbales		wek.	144	relevi		2 4 No		OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIB			S 'NO		N 🗆			
EXAMINER?	OSPITAL:		OTHER:	lome 5 🗆 Residence	6 Other (Specific)			
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c.	INJURY AT	28d. DESCRIBE HO	W INJURY O	CCURED	
1 Natural 5 Pending 2 Accident investigation		INJU	M 1[WORK? YES 2 NO				
3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, at	treet, tactory, o	ffica	28t. LOCATION (Stre City or Town, St	et and Numbi ite)	or Rural I	Route Number,
29e. CERTIFIER (Check only one) 1 LERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: C								a) and manner ee stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	1 -			29c. LICENSE NUI				(Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO CO	MALETER CALLET OF	ATH (ITEM AT 17	Defeat)	016	189	>	12-	9-9-
1167 Nora,	POINF	ATH (ITEM 27) (Type,	ful	224	BAC.	NA	10	21229
DEC 2 1994	THE STATE OF	W.D.C.						



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ours after death. Page 6 may be retained by the hospital or attending phy	tending physician and completely filled in by the funeral director, page 5 should be detached for use as the buri	
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ath certificate be executed within	pletely	Munique prior to buriel premation or removal
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	TO DE COMP. ETTER DV DUICESTINAL MATERIAL PARTICIONES
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at ence.
he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, ral.	TO THE-FUNERAL SECTION AS THE CONTROL OF THE ACCOUNTING PHYSICIAN AND COMPLETELY FILLED IN THE FUNERAL SECTION OF ACCOUNTS AS THE BUNIAL-TRANSIT PERMIT. PAGES 1, be filed within 72 hours that can with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OF SUTTLEMENT PHYSICIAN: The law requires that the death cartificate be executed within Jurs after death. Page 6 may be retained by the hospital or attending physician.
BALTIMORE, MARYLAND 21215-0020	DIVISION OF VITAL RECORDS, P.O. BOX 68760,
	4

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Lest)	Class		IOAT E OT	DEATH	2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (in yrs. last blandey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Dec. 10	1994	THPLACE (State or Foreign
	218–10–5458	1 ☑ M 2 ☐ F	84 YRS.	MONTHS DAYS	HOURS MIN,	(Month, Day, Year) Jan. 12,19	Cou	ryland
Œ	sa. FACILITY NAME (If not Institution, give st Frederick Villa N				onsville		9c. COUNTY OF	timore
CTO	RESIDENCE OF DECEDENT			Cat	OHSVILLE		Dai	CINOIE
DIRECTOR	Maryland Bal	ltimore	10c. CIT	Y, TOWN OR LOCAT	sville			10d. INSIDE CITY LIMITS?
	104. STREET AND NUMBER	remore			ZIP COOE		10g. CITIZEN Of	1 TYES 2 NO
FUNERAL	201 Newburg Aveni	ie			2122	8	U	.S.A.
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO	U.S. ARMEO 2 NO ATES	If yes, sp		IIC ORIGIN? (Specify Year n, Puerto Rican, etc.)	Bid	ICE — American Indian, ack, Whita, atc. ecity:
	15. DECEDENT'S EQUO	CATION	18a, DECEDENT'S	USUAL OCCUPATION	ON .	16b. KIND OF BUSI	NESS/INDLISTBY	White
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of v life. Do NOT us	work done during me	st of working	TOOL KIND OF BOOK	NE33/MOOSI AT	
MP	10 17. FATNER'S NAME (First, Middle, Last)		Personne	el Manag			acturin	g
8	Everett C. Chaney	y				ME (First, Middle, Maiden St. Leonard	umame)	1
TO BE	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town,		
F	Patricia Savage					nsville Mar		
	1 S Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	oval from State 20b	PLACE AND DATE OF THE CONTROL OF THE	ther place)	etery 12	/13/94 Balt	ATION — City or	Town, State Maryland
	21. SIGNATURE OF TUNERAL BERVICE LIC	ENGER V	w Caule	22. NAME A	O ADDRESS OF FA	CILITY		
	Jusque	NER				sell C Witz		eral Homes
	23. PART I. Entar the diseases, or c ehock, or heart fallure. I	omplications that caused List only one cause on a	the deeth. Do n	ot enter the mo	de of dying, suc	h aa cerdiec or respire	atory erreat,	Approximate interval Between
	immediate cause (Finel disease or condition resulting in death)	I. RES DO OUE TO (OF AS A	IVAT	ory	fa	lure	2	Onset and Death
×	Sequentially list conditions,	Pneu	mor	nia				
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	F):				
E	CAUSE (Diseese or Injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF	F):				
H	resulting in deeth) LAST	1						
A	PART II. Other significant conditions	s contributing to death b	ut not resulting	in the underlyin	ceuse given in	Part I. 24s. WAS AN A		4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDIC						1 YES 2 (MO	COMPLETION DF CAUSE OF DEATH?
	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES I NO			1 TES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		0.1002 01	26. PI	ACE OF OEATN (Ch			
PHYSICIAN:	1 🗆 YES 2 🕽 MO	HOSPITAL: 1 Inpetlent 2 ER/Outp			e 5 🗆 Rasidence	8 Other (Specify)		
	27. MANNER OF DEATN 1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	URY AT PRK? YES 2 NO	28d. OEŞCRIBE NOW IN.	JURY OCCURED	
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide detarmined	28a. PLACE OF INJURY building, atc. (Spec	— At home, term, a		11.	281. LOCATION (Street an City or Town, State)	d Number or Run	al Route Number,
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PNYSIC	CIAN: To the best of my know	ledge, death occurre	ed at the time, date	and place, and due	to the cause(a) and menn	ner as stated.	
OM	a made	R: On the beals of examination						e(a) and menner as stated.
H	AND THE AND TITLE OF CENTIFIER	m M	edical	and	29c. LICENSE NUI	MBER 2823/	29d. DATE SIGN	ED (Month, Day, Year)
8	SOVIAN S	STM a	ATH (ITEM 27) (Type,	Print) _MD	5411	Old Fre	deric	K Rd 21219
	DECI 2 1994	32 REGISTRAR'S CON	Li					

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

					CAIL	· OF	DEAL	n		REG. NO.			
1 8	1. DECEDENT'S NAME (First, Middle, Last) MARGARET	MARY	·		DEAL	ΟY			2. DATE OF MONTH DEC.	0EATH 4, 1	994	YEAR	3. TIME OF DEATH 7:20 P
	4. SOCIAL SECURITY NUMBER 216-10-9402	5. SEX 1 M 2 F	6. AGE (In yrs. I	est birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 2	4 HRS. MIN.	7. DATE OF (Month, D DEC.	BIRTH lay, Year) 2, 1	6. BIRTHPLACE (State or Fo. Country) MARYLAND		v)
	9a. FACILITY NAME (If not institution, give	atreet and number)	-		9b. CITY, TOWN OR LOCATION OF DEATH							NTY OF DE	
10 10 10 10	MANOR CARE RUXTO	2.5									LTIMO		
<u>U</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TV.		T 40. 017	W 200000								
DIRECTOR	MARYLAND BA	ALTIMORE			Towson						10d. INSIDE CITY LIMITS? 1 — YES 2 🔀 NO		
FUNERAL	100. STREET AND NUMBER 7001 N. Charles	s St.			10f. ZIP CODE 21204						109. CITIZEN OF WHAT COUNTRY?		
2	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	RMED	13 W	WAS DEC			IIC ORIGIN? (Consider Van			American Indian
BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	NO	10	yes, spe	ecify Cuben, 2 [X] NO	Mexican	n, Puerto Rica	in, atc.)		Black Specifi Whi	,		
	15. OECEDENT'S EDU	JCATION	16a. D	ECEDENT'S	USUAL OC	CUPATIO	N		16b. KI	ND OF BUS	SINESS/INC		
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	- (Give kind of fe. Do NOT u	work done d se retired.)	uring mos	st of working						
COMPLETED	12 yrs	College (14 of 5+)		House	rri fo					TT-			
N.	17. FATHER'S NAME (First, Middle, Last)			nouse	wite	-	40. 14000110			wn Ho			
									ME (First, Mide				
BE	JOHN J. LYNG								RET M				
2	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS	(Street a	nd Number o	r Rural R	Route Number,	City or Tow	n, State, Zip	Code)	
-	Michael Recher			515 F	airmo	ont	Ave.	Tow	son,	Md. 2	21286		
	20a. METHOD OF DISPOSITION 1 Burial 2 Sermation 3 Ram	WINNESS AND	20b. PLACE	EANDDATE	OF DISPOSI				OATE	_		City or Tov	wn, State
	4 Donation 5 Other (Specify)	noval from Stata	Hill	top S	ther plece)	~ C	orp.		12-7	TOTA	on	БM	
1 1	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	F77502	cop c			ID ADDRESS		CILITY	TOWE	OII,	Mu.	
1 1	1	//			I	Ruck	Tows	son	Funer	al Ho	me,	Inc.	
	1-11	1		_		1050	York	Rd	. Tow	son,	Md.	21204	4
	23. PART I. Entar tha diseases, or	complications that	causad tha d	laath. Do	not anter	tha mo	da of dyin	g, such	as cardiac	or respi	retory arr	rest,	Approximate
	shock, or hasrt failura. IMMEDIATE CAUSE (Final	List only one caus	e on aach iin	18.		_							Interval Between Onset and Death
	disease or condition		ACer	Ve	<	4	roks						Onset and Death
	reaulting in death)	a. DUE TO	OR AS A CONSI	FOLIENCE O		9 1	000				-		day
1_1	DUE TO (OR AS A CONSEQUENCE OF):							/					
CERTIFICATION	Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF):												
A	if sny, laading to immediate cause. Entar UNDERLYING	,			- ,-								į
[윤]	CAUSE (Disease or Injury that initiated events	DUE TO (C	OR AS A CONS	EQUENCE O	F):								1
E	resulting in death) LAST												1
		d											1
	PART II. Other significant condition	na contributing to d	leath but not	resulting	in the unc	derlying	cause giv	van in i	Part I. 24	a. WAS AN			WERE AUTOPSY FINOINGS
EDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									- '	YES 2	□ NO	- 1	OF OEATH?
2	DID TODACCO LICE CONT	DIDLITE TO CAL		4=44		14							1 YES 2 NO
Z	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUIE IO CAL			_	-4	UNCE	RTAIN	1 🗆 📗				
0	EXAMINER?	HOSPITAL:	26. PLA	CE OF OEA	OTHER	· · ·							
YS	1 TYES 2 NO	1 🗆 Inpetient 2 🗀	ER/Outpatient	3 🗆 DOA	4 Num	Ing Home	o 5 □ Raal	dence	6 Other (S	pecify)			
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF II (Month, Day		26b. TIM	E OF JURY M	28c. INJU WOI 1 Y		NO	28d. DESCR	BE HOW I	NJURY OCC	CUREO	
	1 260 PLACE DE IN.III.DV — At home form street feetons office.												
4	29a. CERTIFIER				_								
COMPLETED	(Check only one) 1 CERTIFYING PHYS 2 MEDICAL EXAMINI	ER: On the beat of m											and manner as stated.
B	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. OATE SIGNEO (Month, Day, Year) 1 2 5 - G11												
10	30. NAME AND ADDRESS OF PERSON WEDE. A. H. GHILF					, MD	. 212						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE			-							
	DEC1 2 1994 Ju	lia d'audion		6		100							

or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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0	THE THE	101	be filed	IMPOR	
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31. DATE FILED (Month, Day, Year)
DEC1 2 1994

	FOR STATE REGISTRAR		STATE OF I	MARYLAN		PARTMEN				MENTA	AL HYGIEN			
	1. DECEDENT'S NAME (First	INE	P.	1	Dob.	RY				2. DAT MON DE		19	YEAR 94	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 216-14-11	07	1 M 2 F X YRS.				MIN.	MA	Ch S	1912	Country	MARVIAND		
DIRECTOR	98. FACILITY NAME (If not in	Hill	Cowv.	Ho	Me	Pb. cit	AN C	All		OW/	v		IT!	10RE
IRE	Maryland	10b. COUNTY	-			CITY, TOWN								10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	10e. STREET AND NUMBER					- 0.35		f. ZIP COD	E			10g. CIT		HAT COUNTRY?
FUNERAL	702 S. Pot	omac S	St.					2	1221	+			U.S.	.A.
ВУ	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO	13	If yes, ap	CENDENT Concepts Control of the Cont	in, Maxicai	n, Puerto	IN? (Specify Ye Rican, etc.)	s or No—	14. RACE Black, Specify Who	- American Indian, White, atc.
TED		EDENT'S EDU		10	6a. DECEDEN (Give kind	NT'S USUAL of of work done OT use retired.	OCCUPATION DE during me	ON ost of workli	ng	16	b. KIND OF BL	ISINESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (t	1-12)	College (1-4 or 5	+)		ewife					Home	make:	r	
NO.	17. FATHER'S NAME (First, M							16. MOT	HER'S NAI	ME (First,	Middle, Maider	Sumame)		
BE (George Ada		Biel								Kraje			
10	Eugene Dob				196. MAIL	4 Win	ss (Street) and z	Rd.	r or Rural F	nda]	mber, City or For LISTOW	n, State, Zi	d . (21133
	20a, METHOD OF DISPOSIT 1 & Buriel 2 Crematic 4 Donation 6 Other	n 3 🗆 Rem	oval from State	20b. P	ther place)	sposition (i nisla	us C	emet	matory or cery	Dec	200.10	Balt:	imor e	m, State e, Maryland
	21. SIGNATURE OF SUBERA	A. We	a.We	serel	Puls	22	NAME A	ND ADDRE	SS OF FA	CILITY	& Son			
	IMMEDIATE CAUSE (Findisease or condition	eart feilure.	complications the List only one cer	ise on sec	h iine									Approximate interval Between Onset and Death
	reauiting in death)	_	DUE TO	(OR AS A C	ONSEQUENC	E 093	0.5	l-	1	AV	lent-	ile a	en	
ATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY	diate ING	DUE TO	(OR AS A C	ONSEQUENC	18-OP)		30	en-					
CERTIFICATION	CAUSE (Disease or inju that initieted events reaulting in death) LAS		DUE TO	(OR AS A C	ONSEQUENC	CE OF):								
MEDICAL CI	PART II. Other algnifica	_	e contributing to		not resulti	ing in tha u	ındariyin	g cause	given in	Part i.	24a. WAS AI PERFO	RMED2		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
Z Z														
PHYSICIAN:	25. WAS CASE REFERRED Y EXAMINER?	O MEDICAL	HOSPITAL:			отн	R:	LACE OF D						
HYS	1 YES 2 NO		1 Inpatient 2 (INJURY		TIME OF	28c. IN.	JURY AT	asidence		ter (Specify) ESCRIBE HOW	INJURY OC	CURED	
ВУ Р	1 Natural 5 2 Accident	Pending Investigation	(Month, I	Day, Year)		INJURY M		YES 2	□ NO					
9	a Distribution —	Could not be determined	28e. PLACE (building	OF INJURY — , etc. (Specify,	At home, fa	rm, street, fa	ctory, offic	De .		281, LC	CATION (Street y or Town, State	and Numbe	r or Rural R	oute Number,
COMPLET	cont only		ICIAN: To the best o											and manner as stated.
BE CC	29b. SIGNATURE AND TITLE			11		-		29c. LIC	ENSE NUM	MBER	_		TE SIGNED	(Month, Day, Year) O-94
임	30. NAME AND ADDRESS O	F PERSON WH	IO COMPLETED CAL	ISE OF DEAT	H (ITEM 27) ((Type, Print)		V		60		<u></u>	12-1	- 19

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fine with the State death with the State Dept. Of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	DEPARTM	ENT OF HEALTH AN	ND MENTAL H	YGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	notendia			2. DATE OF MONTH		3. TIME OF DEATH O'. HO M	
	214-30-5570	1 D M 2 D E 88	88 YRS. MONTHS DAYS HOURS MH			BIRTH By, Year) .5,1906	BIRTHPLACE (State or Foreign Country) POLAND	
2	96. FACILITY NAME (If not institution, give stree LEVINDALE RESIDENCE OF DECEMENT	BALTIMORE				9c. COU	JNTY OF DEATH	
DIRECTOR	100. STATE 10b. COUNTY MARYLAND				0N 10d. IN Li 1 □X			
FUNEHAL	100. STREET AND NUMBER 3400 HATTON RD					21208 10g. CITIZEN OF WHAT COUNTRY? USA		
2	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 ☐ YES 2 IF YES, GIVE WAR OR DATES	₩ NO	13. WAS DECENDENT OF H If yes, specify Cuben, N 1 YES 2 NO	lexican, Puerto Rica		14. RACE — American Indian, Black, White, atc. Specify: WHITE	
COMPLEIED	15. DECEDENT'S EDUCA (Specify only highest grade co	AL OCCUPATION lone during most of working red.)		ND OF BUSINESS/INI	DUSTRY			
DE COM	17. FATHER'S NAME (First, Middle, Lest) JACOB TESLER 16. MOTHER'S N. BLU					fle, Maiden Surname)		
2	190. INFORMANT'S NAME (Type/Print) MRS . ESTHER SOKOI		3400 H		BALTO.	MD -211206	3- 21208	
	20xxMETHOD OF DISPOSITION 14Y Buriel 2 Cremetion Remove 4 Donation 5 Oth Process 1. SIGNATURE OF FUNETAL SEES 1992 CE	at from Statu of eme	tary, crematory or o			D) 12/8/9	Otty or Town, State 94 ROSEDALE, MD	
	May	Jenn	/	SOL LEVINS	ON & BRO	BALTO	21215 D., MD 2112115	
	IMMEDIATE CAUSE (Finel disease or condition	st only one cause on each	lina.	the mode of dying	, such as cardiac	or respiratory ar	Approximate interval Between Onset and Death	
2	DUE TO NOT AS A CONSEQUENCE OF: Cerebrel vascular accident							
HIFICALION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO OR AS A CONSEQUENCE OF): DUE TO OR AS A CONSEQUENCE OF):							
5	resulting in death) LAST							
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
	1 Tes 2 NO							
5	EXAMINER?	HOSPITAL:	nt 3 🗆 DOA 4 🗓	26. PLACE OF DEAT		inec/fv)		
BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK? 1 YES 2 N	28d. DESCR	IBE HOW INJURY OF	CCURED	
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — A building, etc. (Specify)	kt home, farm, atree	ome, farm, atreet, factory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
COMPLEIED	29e. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner as stated. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner as stated.							
O BE	296. SIGNATURE AND TITLE OF CERTIFIER Physican: 28c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day): Hong Are 714 1994							
	30. NAME AND ADDRESS OF PERSON WHO SUNIL P- 31. DATE FILED (Month, Day, Year)	INFITA	2434	W Belve	dese A	ve Ba	Ho Md 21215	
	DEC 1 2 1994	32. REGISTRAR'S SIGNATUR	lall					

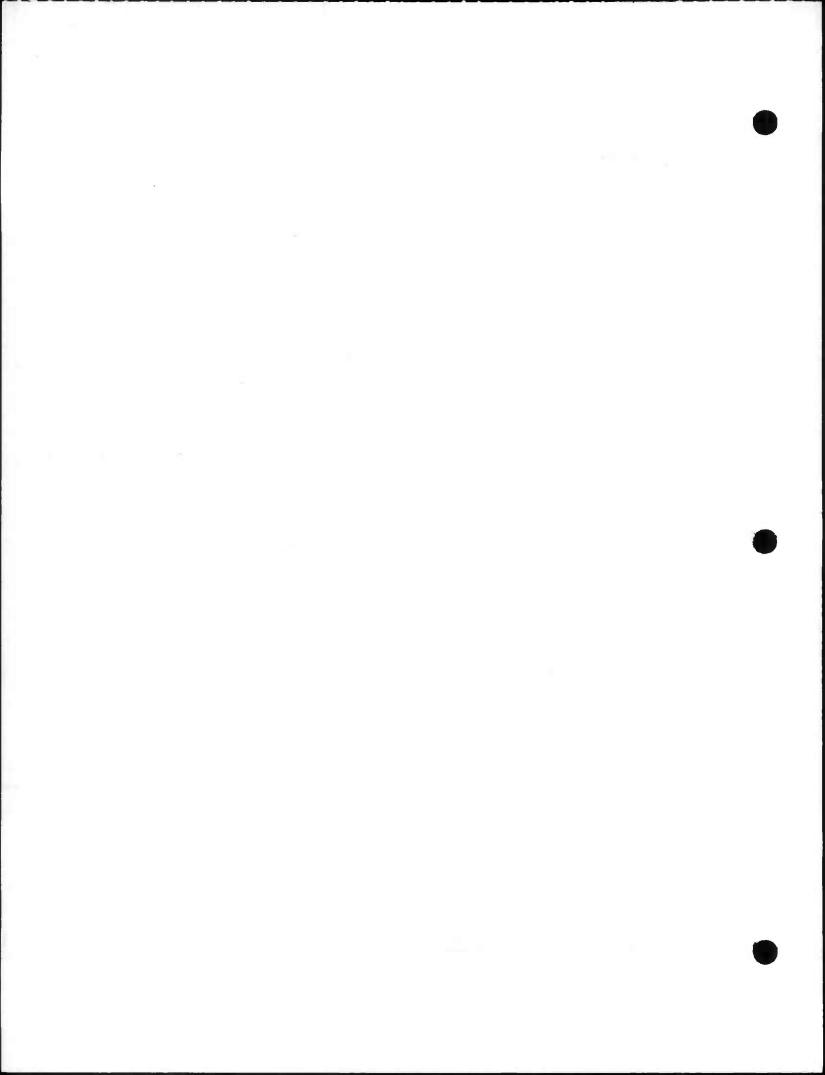
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exclours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	DEPARTMENT	OF HEALT	H AND	MENTAL	HYGIENE	
	CI	ERTIFICATE	OF DE	HTA		REG NO	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
1	Josephine Fe	sephine Ferraro			December 8 1994 7:55 p					
3	4. SOCIAL SECURITY NUMBER S	6. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	THPLACE (State or Foreign		
	212-09-6854 1 9a. FACILITY NAME (If not institution, give stree	M 2 X F	91 YRS.	MONTHS DAYS	HOURS MIN.			aryland		
œ					ille	EATH	Baltin			
DIRECTOR	RESIDENCE OF DECEDENT									
2				TOWN OR LOCATION				10d. INSIDE CITY LIMITS?		
	Maryland			Baltim				1 X YES 2 NO		
FUNERAL	10e. STREET AND NUMBER				ZIP CODE			WHAT COUNTRY?		
N.	4306 Arizona Avenue			21206				ed States		
	t Naver Married 2 Married FORCES? 1 YES 2 X		2 X NO	NO If yes, specify Cuban, Maxican		n, Puerto Rican, etc.)		CE — American Indien, ck, White, alc.		
BY	3 ☒ Widowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES			1 TES 2 X NO Specify:			Specify:			
COMPLETED	15. DECEDENT'S EQUCAT (Specify only highest grade cor	TION .	18a. DECEDENT'S L	SUAL OCCUPATION	IN .	16b. KIND OF BUS	SINESS/INDUSTRY			
		College (1-4 or 5+)	life, Do NOT use		st or working					
MP	6		Home	emaker						
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden				
BE	Augustine Pisto	<u>r10</u>				C. Cellur				
9	19a. INFORMANT'S NAME (Type/Print) Mrs. Carrie T. Bec	kor			Avenue	Baltimore		21206		
	20a. METHOO OF DISPOSITION		PLACE AND DATEO				CATION — City or 1	21206		
	1 N Burial 2 Cremetion 3 Ramova 4 Donation 5 Other (Specify)	of from State cemet	tery, cremetory or oth	er place)						
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE Mark T 7			D ADDRESS OF FA	2/12/94 Ba	TUTILIOTE,	Marylanu		
	> Mach T. &	Barafre 2	.avoyna		ard J. R Harford	luck, Inc.	ltimoro	Md. 21214		
	23. PART I. Enter the diseese, or con ehock, or heert fellure. Lie	nplicetione that caused t	the death. Do no	ot enter the mo	de of dying, auc	h es cerdiec or reepi	ratory erreet,	Approximete		
	IMMEDIATE CAUSE (Finel					\bigcirc \bigcirc		Intervel Between Onset and Death		
	disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):									
_	A S C VY									
9	Sequentielly liet conditione, If eny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
CA	CAUSE (Disease or Injury									
	that initiated evente resulting in death) LAST	OUE TO (OR AS A C	CONSEQUENCE OF							
CERTIFICATION	d.									
AL 0	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
S	Althumens clusters PRIOR TO COMPLETION OF CAUSE									
ME								OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: ONNED:									
YSI	1 TES 2 NO	☐ Inpatient 2 ☐ ER/Oulput	lent 3 DOA		5 🗆 Residenca	8 Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY WO	RK?	28d. DESCRIBE HOW IP	NJURY OCCURED			
B	2 Accident Investigation	28. BLACE OF IN HUM	Albana di sa sa		ES 2 NO					
COMPLETED	3 Suicida 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, atc. (Specify	~ Al nome, term, at	reet, fectory, office		28f. LOCATION (Street a City or Town, State)	ind Number or Rural	Route Number,		
Ë	29a. CERTIFIER CERTIFYING PHYSICIA	29a. CERTIFIER OF CERTIFYING BUYESICIAN. To the hord of The hord o								
ME	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end menner as stated. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end menner as stated. MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.									
	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)									
BE	Loward	1 HZ 0				93		9 -94		
유	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF OEAT	H (ITEM 27) (Type, I	Print)	10 (17			1 1		
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE							
	DEC1 2 1994	: Whiteer have	4							

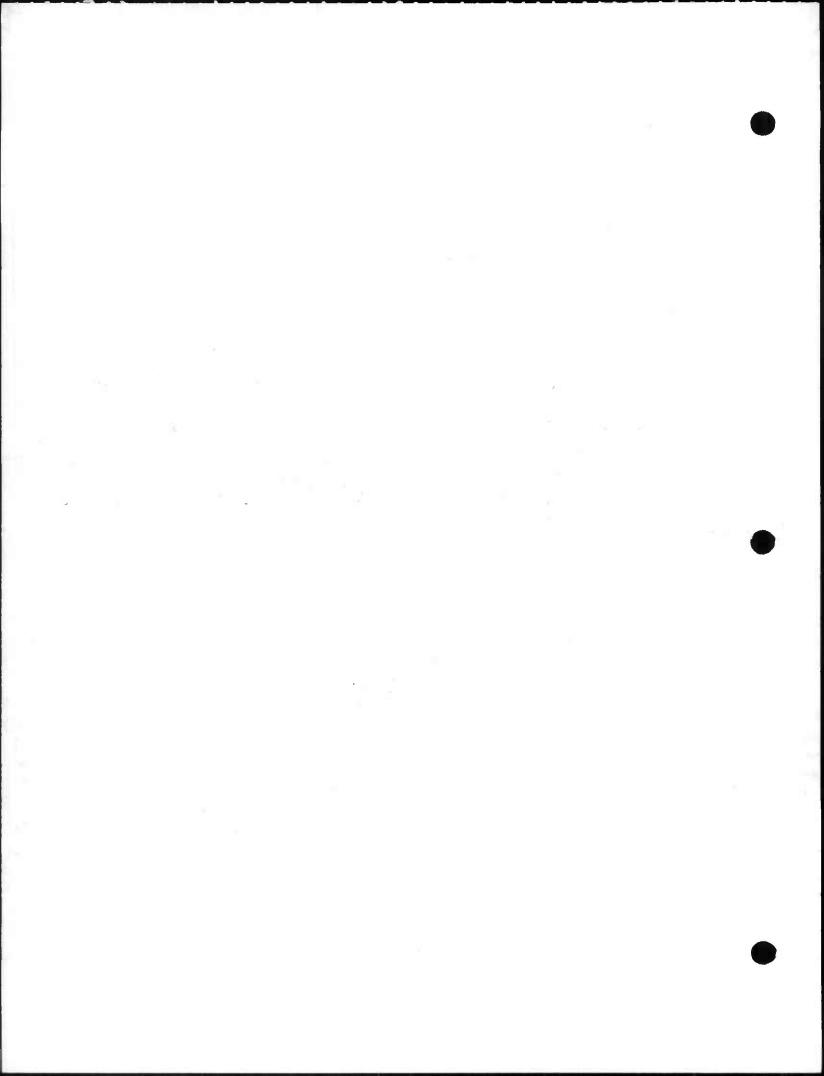


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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) Helen Fisch	ner				2. DATE OF DEATH MONTH D	AY - 94	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 215-48-8454	5. SEX 6. AGE		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAR . 24,19		BIRTHPLACE (State or Foreign Country) HUNGARY	
OR		of Baltim		13 11	IMORE		9c. COUNTY		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE MARYLAND 10b. COUNTY	1	10c. CITY, TO BALTI	OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?	
FUNERAL	100 STREET AND NUMBER 6603 PARK HEIGHTS AVE., APT. A-2				101. ZIP CODE 10g			N OF WHAT COUNTRY?	
B⊀	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES.			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			or No- 14	Black, White, etc. Specify: WHITE	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE			done during mo: tired.)	done during most of working			TRY	
BE CON					18. MOTHER'S NA BLIE	ME (First, Middle, Meiden MAH		ADLER	
5	190. INFORMANT'S NAME (Type/Print) MR. EUGENE FISCH	ER				Aoute Number, City or Tow			
	MR. EUGENE FISCHER 6606 GREENSPRING AVE. BALTO., MD 21209 200x METHOD OF DISPOSITION DATE 200x. LOCATION — City or Town, State Commetter, crematory or other place) SHOMREI MISHMERES SCHARES HAPLATA 12/9/94 ROSEDALE, MD 22. NAME AND ADDRESS OF FACILITY								
	Manuff	Donnas	_	SOL LE	VINSON &	BROS., IN		MD 21215	
	IMMEDIATE CALICE (Elect	a. Ne crof	ech ilne.	enter the mo	de of dying, suc	h as cerdiec or reep	ratory arreet	t, Approximate Interval Between Onset and Daath	
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): ### Hours ### Hours ### Hours ### Hours ### Due to (OR AS A CONSEQUENCE OF): ### Due to (OR AS A CONSEQUENCE OF): ### Due to (OR AS A CONSEQUENCE OF): #### Due to (OR AS A CONSEQUENCE OF): #### Due to (OR AS A CONSEQUENCE OF): #### Due to (OR AS A CONSEQUENCE OF): ###################################								
MEDICAL	Coronary artery disease diabetes mellitus 1 yes 2 × NO OF						24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?								
IYSI	199 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	atlent 3 DOA 4			8 Other (Specify)			
BY PH	1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		RK?	28d. DESCRIBE HOW I	NJURY OCCUR	RED	
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, lectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							Rural Route Number,	
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the firme, date end place, end due to the cause(s) end manner es stated.								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER . M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Yber) 12 - 8 - 94		
	A THUY	oday, J.	C., M.	Ď.					
	31. DATE FILED (Month, Dey, Year) DEC12 1994	4 July Diwels	aturé or Radill						



BALLIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical examiner must be notified at once.
CINESTON OF VITAL RECORDS, F.O. BOX 601601	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fine and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IN ORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CER	TIFICAT	E OF	DEATH	REG.	NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	Н		3. TIME OF DEATH
	SUSAN CHRISTINA	FLEMING				December	O4,	1994°	4:40 P. M
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last bir		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		6. BIRT	HPLACE (State or Foreign
	213-30-3270 1□ № 2 🖫 🗆	97	YRS. MONTH	DAYS	HOURS MIN.	June 04	1897	Count	ryland
	9a. FACILITY NAME (If not institution, give street and number)		9b. C	TY, TOWN	OR LOCATION OF DI			UNTY OF C	~
DIRECTOR	Manor Care Towson			-	Towson			Balti	more
<u> </u>	10a. STATE 10b. COUNTY	16	Oc. CITY, TOW	OR LOCA	TION				10d. INSIDE CITY
	Maryland Baltimore		1	owsor					LIMITS?
FUNERAL	100. STREET AND NUMBER 509 E. Joppa Road			10	2128	36	10g. CI		WHAT COUNTRY? J.S.A.
5		EVER IN U.S. ARMED) 1		ENDENT OF HISPAN			14. RAC	E — American Indian, k, White, etc.
BY	1 Never Merried 2 Merried IF YES, GIVE WA	R OR DATES			ecify Cuban, Maxica 2 NO Specify		,	Spec	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18e. DECED	ENT'S USUAL	OCCUPATION	ON	16b. KIND OI	BUSINESS/I	OUSTRY	
ᇦ	Elementary/Secondary (0-12) College (1-4 or 5+)	Iffin Do	not of work don NOT use retired	e during mo !.)	st of working				
AP.	12 years	Pos	tmistr	ess		Pos	stal Se	ervic	e
ő	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Ma			
BE C	Frederick August Brunner				Susan	Laumann			
	19a. INFORMANT'S NAME (Type/Print)	19b. M	AILING ADDRE	SS (Street a	nd Number or Rural I		Town, State, 2	(ip Code)	
2	Wilbur Jensen				vinia Av				land 21204
1	20g. METHOD OF DISPOSITION	20b. PLACE AND				-	LOCATION -		
	1 N Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ore, Maryland							
ĺ	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Green	2	2. NAME AI	ID ADDRESS OF FA	CILITY		,	Tate y Laria
	George 1. Corrane			Mitch	nell-Wied	lefeld Ho			
-				6500	York Roa	nd Balti	more,	Mary	land 21212
	23. PART I. Enter the disease, or complications that abock, or heart fallure. List only one caus	caused the death e on aach ilne.	. Do not ant	er tha mo	da of dying, suc	h aa cardlac or r	aspiratory a	rraat,	Approximata Interval Between
1	IMMEDIATE CAUSE (Final disease or condition	N - 1			1	W. ~			Onset and Death
	disease or condition	0-1461	IKAT	OR Y	1-112	UKE			DUAYS
1		S (V)	NCE OF):						10/1-
CERTIFICATION	Sequentially list conditions,	OR AS A CONSEQUE	MCE OED-						1 ANDER 7
AT	If any, leading to immediate cause, Enter UNDERLYING								
윤	CAUSE (Disease or Injury that Initiated events	OR AS A CONSEQUE	NCE OF):						
E	resulting in death) LAST								1
8 8	d								
A	PART II. Other algorificant conditions contributing to d	eath but not rasu	iting in tha	underlying	cause givan in	Part I. 24a. WA	S AN AUTOPSY	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL	Serile Demention	V /4	nul	nu	us	1	S 2 NO		COMPLETION OF CAUSE OF DEATH?
ш		/					X		1 VES 2 NO
PHYSICIAN: M	DID TOBACCO USE CONTRIBUTE TO CAU	ISE OF DEATH	YES 🗆	NO [UNCERTAIN	10		- 1	
Ĭ.	25. WAS CASE REFERRED TO MEDICAL		F DEATH (Chec						
S	EXAMINER? 1 YES 2 NO 1 Inpetient 2 1	ER/Outpatient 3 🗆 (OOA 4 X N		e 5 🗆 Realdence	6 Other (Specify)			
主	27. MANNER OF DEATH 28e. DATE OF II	NJURY 28	b. TIME OF	28c. INJ	URY AT	26d. DESCRIBE H		CCURED	
	1 Netural 5 Pending (Month, Day,	Year)	INJURY M	1 🗆 1	RK? 'ES 2 NO				
BY	3 Suicide 28e. PLACE OF	INJURY — At home,	farm, street, fa	ctory, office		28f. LOCATION (St	reet and Numb	er or Rural I	Poute Number
COMPLETED	4 Homicide determined building, et	c. (Specify)				City or Town, S	tate)		10-2-221
" "	29a. CERTIFIER A CERTIFYING PHYSICIAN, To the head of	no beautiful and a distant	Attack your		76-71 St. 181			/;	
₽	(Check only one) 2 MEDICAL EXAMINER: On the best of many one)								
8		THE STATE OF THE S	rigation, in m	opinion, o	sath occured at the	time, data and plac	i, end due to	the ceuse(s	i) and manner as stated.
꾦	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM		29d. DA	TE SIGNED	(Month, Day, Year)
ē	inay, M.V.				D-14	418		12.	6-94
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE								
/	Bienvenido Matos 21 Crar	brook Ro	ad Co	ckeys	sville, N	Maryland	21030		0
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR	S SIGNATURE							
	DEC1 2 1994 This Daveler	nankall						2.5	

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the feath. Page 6 may be retained by the hospital or attending physician.

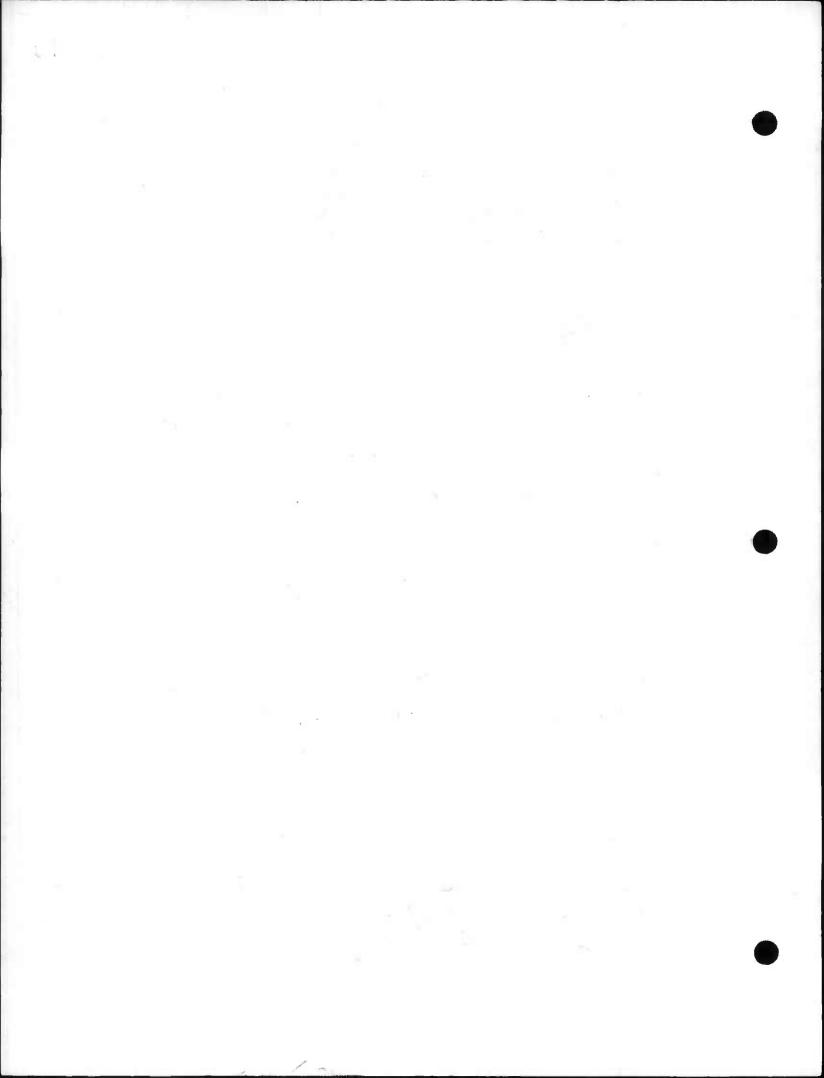
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should seem after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DMONTH 1. O DAYCO A YEAR 44. O DAYCO A YEAR													
	EL.	SIE	MONTGOMER	RY GAL	VIN					December 8,7994 YEAR 11:35A			11:35A M	
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. les	birthday)	IF UNDER		IF UNDER		7. DATE OF B	HRTH Wheel		8. BIRTH	PLACE (State or Foreign
	212-52-8099		1 □ M 2)()(F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	May 4,	1913		Vi	rginia
	9a. FACILITY NAME (# not in					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							EATH	
ן מַ	4300 N. Char		Apt. 2D			Baltimore						N/A		
မှူ	10a. STATE	10b. COUNT	Y		10c. CITY, TOWN OR LOCATION									10d, INSIDE CITY
픕	Maryland	1	√ A			Baltim	ore							LIMITS?
A.	10e. STREET AND NUMBER						101	. ZIP CODI	E			10g. CiTI	ZEN OF W	VHAT COUNTRY?
FUNERAL DIRECTOR	4300 N. Charle	es St.	Apt. 2D					212	18				USA	
2	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13. V	AS DEC	ENDENT C	F HISPAN	IC ORIGIN? (S	pecify Yes	or No-	14. RACE Black	— American Indian, c, White, atc.
B	3)(X) Widowed 4 Dive		IF YES, GIVE W	AR OR DATES		1	☐ YES	2XX NO	Specify				Specif	white
	15. DEC	EDENT'S EDU	CATION	18a. DE	CEDENT'S	USUAL OC	CUPATIO	ON		16b. KIN	D OF BUS	INESS/INC	USTRY	MITOC
Ē	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) Lifementary/Secondary (0-12) College (1-4 or 5 +) Lifementary/Secondary (0-12)													
Į į	4 Homemaker Own Home													
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)													
BE	Stewart Montgomery Julia Montgomery													
임	G.A.Galvin Jr. 19a. INFORMANT'S NAME (Type/Print) G.A.Galvin Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4300 N. Charles St. Baltimore Maryland 21218													
	20a. METHOD OF DISPOSIT	ION	-	20b. PLACE					ai tilli	DATE		CATION -		wn State
	1 Donation 5 Other	(Specify)	oval from State	Green	matory or of	her plecel	rv			1				1.00
at Signature of Funeral Service Licenses A Donation S Other (Specify) Cemetery, crematory or other piece) 12/9 Baltimore, Maryland													y I di lo	
	Dennis	Mu	1 Hen MC	na b		6	500	Vovde		nell-wie Baltimor				10
	23. PART i. Enter the d	Iseases, A	complications tha	t caused the de	ath. Do n	ot enter	the mo	de of dy	ing, such	es cerdiec	or respin	retory an	rest,	Approximate
	iMMEDIATE CAUSE (Fir		List only one cau					•						Interval Between Onset and Death
	diseese or condition reaulting in death)	→	· Ca	nano	ma	9	1	re, hi	T 6	ime				2413
			DUE TO	(OR AS A CONSEC	UENCE OI	ŋ: 7	,			1		-1		
ON	Sequantially list condit		b. DUE TO	MOM (0 751	me	m	4/	Inli	una	ny	des	KAR	2 yrs
AT	if any, leading to imme cause. Enter UNDERLY	ING		(orring)	OLITOL OF	7-		,						į į
F	CAUSE (Disease or injuthat initieted events		DUE TO	(OR AS A CONSEC	UENCE OF	7):								
CERTIFICATION	resulting in death) LAS	T	d											
0	PART ii. Other significa	nt condition	s contributing to	death but not r	esuiting i	n the und	deriyin	g ceuse g	given in I	Part I. 24s		AUTOPSY	24b.	WERE AUTOPSY FINDINGS
S	Throm by	phi	STNK	O	cr	1991					PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
MEDICAL										_ ' '	, 123	×		OF DEATH? 1 YES 2 NO
ä	DID TOBACC	O USE	CONTRIBUTE	TO CAU	SE OF	DEAT	H Y	ES X	NO					
CIÀ	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTUED		ACE OF D	EATH (Che	ck only one)				
PHYSICIAN:	1 TYES 2 NO		1 Inpetient 2		□ DOA	OTHER	ing Hom	6 5 Re	sidence	8 Other (Sp	ecify)			
	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, D		28b. TIM	E OF URY	WO	URY AT		28d. DEŞCRIE	BE HOW IP	NJURY OC	CURED	
B	2 Accident	Investigation	28a, PLACE O	F INJURY At ho	ne ferm e			YES 2	NO	28f. LOCATIO	N (Dane)			15/1
COMPLETED	4 Homicide	Could not be determined	building,	atc. (Specify)	110, 101111, 0	KIDDI, INCIO	ry, ome		1		wn, State)	na Number	or Murai H	ioute Number,
'n	29a. CERTIFIER 1 CERT	TIFYING PHYS	ICIAN: To the best of	my knowledge, de	ath occum	od at the Ur	ne dete	and place	and due	to the cause(s)	and man		and	
No.) and manner as stated.
8	29b. SIGNATURE AND TITLE	_		1	A 1	5			ENSE NUM					(Month, Day, Year)
2	Wim	Carl	W	lue.	M	(d)			20 4	577		•	12-	9-94
F	30. NAME AND ADDRESS OF	PERSON WH	EBEL	SE OF DEATH (ITE	1 27) (Troe,	Print)	40	10	see	i In	A	alt	מו נד	1 2120xf
	DEC1 2 19	Year)	34. REGISTRA	R'SOIGNATURE		-				- 10			- 10	
	DECT % 19:	34 Ju	UA WILLIAM	- Amount										



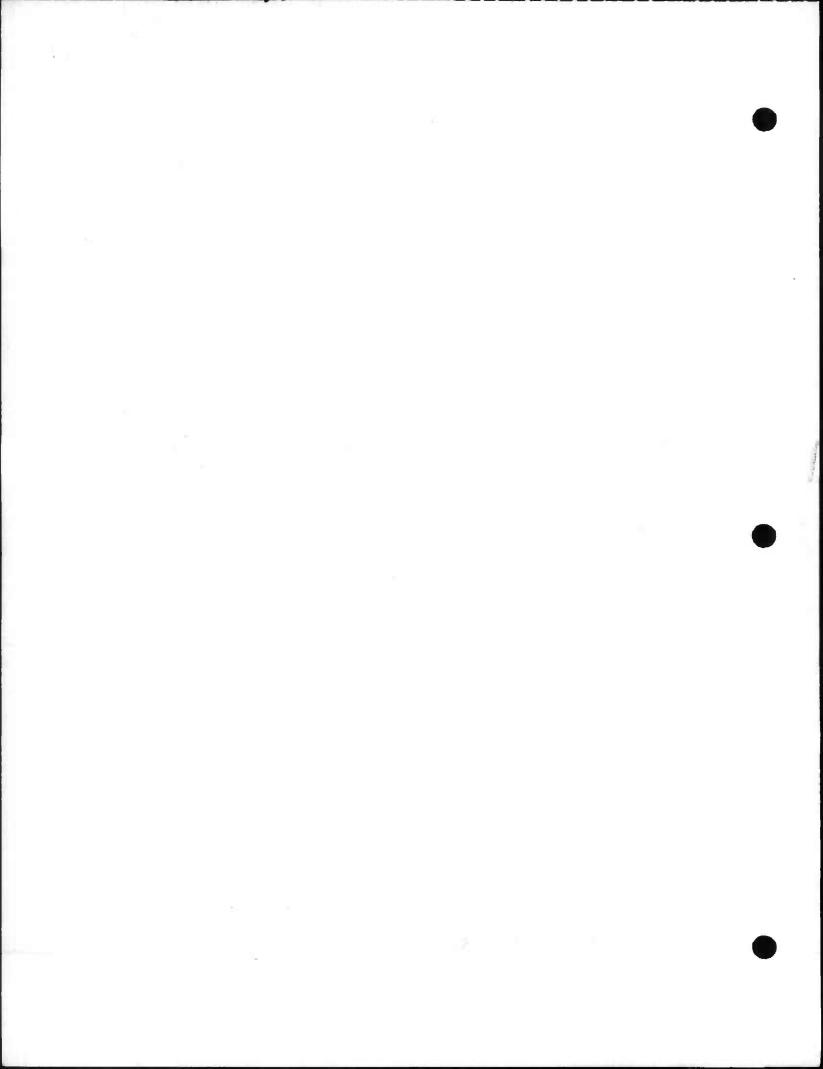
mit. Pages 1, 2, 3 should

1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760

94 36611 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH DAY 3. TIME OF DEATH Gas King 9 4

	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	213-20-6069	1 🗆 M 2 🂢 F	/ O YRS.			05,24	1924	ind
~	9e. FACILITY NAME (it not institution, give str		~ 0	0 11	OR LOCATION OF DI		9c. COUNTY	OF DEATH
DIRECTOR	GOOD SUMANTON	hospit	M	115am	mon	MO.		
E	10e, STATE 10b, COUNTY		10c, 0	TY, TOWN OF LOC	ATION			10d. INSIDE CITY LIMITS?
ā	(M).		K	2a/40				1 YES 2 NO
FUNERAL	6225 VUY	K R	d	1	DI. ZIP CODE	2	10g. CITIZEI	OF WHAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. ARMED YES 2 NO			NC ORIGIN? (Specify Year, Puarto Rican, etc.)	s or No- 14	. RACE — American Indian, Black, White, etc.
ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W		1 YE	S 2 NO Specifi			specify: Black
Ë	15. OECEDENT'S EDUC (Specify only highest grade of	CATION completed)	(Give kind o	S USUAL OCCUPAT work done during m	ION nost of working	16b. KIND OF BU	SINESS/INDUS	TRY
COMPLETED	Elementery/Secondery (0-12)	College (1-4 or 5 +	iite. Do NOT	use retired.)		Univ	ersite) Hospita
BE COI	17. SATHER'S NAME (First, Middle, Last)	obinso	~		18. MOTHER'S NA	ME (First, Middle Malden	Sumame) -	
TO B	190. INFORMANT'S NAME (Type/Print)	Uhale-	19b. MAILIN		end Number or Rural	Acute Number, City or Tow	m, State Zip Co	170 md 2124
	20s. METHOD OF DISPOSITION Cremetion 3 - Remo	ival from State	206 PLACE AND DIST	-		: (7/ / 17	1-2	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE/	Mosa	22. NAME /	AND ADDRESS OF FA		01/01	
	· Denne	H. D	humpson	ma 43		-west	Ne	
	23. PART i Enter the diseases, or connect, or heart failure. L	omplications the	t caused the death. Do	not antar the m	oda of dying, auc	h as cardiac or reap	iratory arreat	Approximate interval Batween
	IMMEDIATE CAUSE (Final	0.00	à / 1 = 2		11			Onset and Daath
	resulting in death)	Cer	OR AS A CONSEQUENCE	61707 1	farlure			
_		101	OR AS A CONSEQUENCE	J. 1	1.00			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEQUENCE	0F):	with			
S	cause. Entar UNDERLYING CAUSE (Disease or injury			U				
E	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEQUENCE	OF):				
E	d	·						
	PART II. Other significant conditions	contributing to	death but not resulting	in the underlyle	ng cause givan in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDICAL						1 _ YES :		COMPLETION OF CAUSE OF DEATH?
M					_/			1 TYES 2 NO
AN	DID TOBACCO USE CONTR	IBUTE TO CA		ES NO				
Sign	EXAMINER?	HOSPITAL:	ER/Outpatient 3 DOA	OTHER:		Total and Control William		
PHYSICIAN:	27. MANNET OF DEATH	28e. DATE OF	INJURY 28b, T	ME OF 28c. IN	me 5 Residence	28d. DESCRIBE HOW I	NJURY OCCUR	RED
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ay, Ybar) II		YES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE O	F INJURY — A1 home, farm etc. (Specify)	, stree1, fectory, offi	ce	281. LOCATION (Street City or Town, State)		Rurel Route Number,
COMPLETED	4 Homicide determined					only or yourn, orano,		
			my knowledge, daath occu					
Š	000) 2 MEDICAL EXAMINER	: On the basis of er	semination and/or investigat	lon, in my opinion,	death occured at the	time, data and place, er	d dua to the c	suse(s) and menner ee stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	X	000	_	29c. LICENSE NUI		29d. DATE S	IGNED (Month, Day, Year)
ē.	30. NAME AND ADDRESS OF PERSON WHO	COMPLEYED	DE DEATH STORE OF	- Polos	D253	542	12	107-94
		GOMPLETED CAUS	COP DEATH (ITEM 27) (Ty)		, Ms	11239		
ŀ	31. DATE FILED (Month, Day, Year)	- /	R'S SIGNATURE	2 4 17		01007	•	
	DFC1 2 1994 Ad	develor	Rodall					
	0							DHMH-16 Ray 1/89



		Item1,g-718,12-12- FOR STATE REGISTRAR	94, perf.h., STATE OF'I	dr MARYLAN	ND / DEPAR	TMENT	OF HE	ALTH A	ND ME	NTAL HYGIEN	E		
		1. DECEDENT'S NAME (First, Middle, Las		elle	- Helen					DATE OF DEATH		YEAR 3	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 213-48-2192	5. SEX		yrs. last birthday) 36 YRS.	IF UNDER 1		IF UNDER 24	HRS. 7.	DATE OF BIRTH (Month, Day, Year)	08	Country)	LACE (State or Foreign
2. 3 should	стов	90. FACILITY NAME (If not institution, given Howard County	eneral Ho	spital	1	9b. CITY, T		LOCATION	OF DEATH		9c. COUN	TY OF DEA	тн
Pages 1,	DIRECT	RESIDENCE OF DECEDENT 10.6. STATE 106. COU			10c. CIT	Y, TOWN OR						- 1	0d. INSIDE CITY LIMITS?
t permit.	ERAL D	100. STREET AND NUMBER 7047 IVORY Hand				<u>Co.</u>	Lumb 10f. z	ZIP CODE	21045	-	10g. CITIZ	EN OF WH	TYES 2 NO
DR)	BH FUNE	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Olvorced	12. WAS DECEDED FORCES?	YES	2 NO	11)		NDENT OF	HISPANIC (ORIGIN? (Specify Yes uarto Rican, etc.)	or No—	U.S 14. RACE - Black, Specify	.A. - American Indian, White, atc. White
ND 21215 hospital or and ached for	PLETED	15. DECEDENT'S E (Specify only highest gn Elementary/Secondary (0-12)			life. Do NOT u	work done dur	UPATION ing most	of working		166. KIND OF BU	siness/indu	STRY	MILEC
/LA by the be det	BE COMPL	17. FATHER'S NAME (First, Middle, Lust) Sigmund Brzozkow	ski					Ro	se Kv	(First, Middle, Maiden Vasnik			
MA retain 5 sho	10		Niece)		7047	Ivory	Han	nd Pl	ace (Number, City or Tow Columbia	Maryl	and	21045
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		20a. METHOD OF DISPOSITION Burlal 2 Cremation 3 Ri Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE		st.	LACE AND DATE Pry, cremetory or o Stanis	laus (Ceme	ADDRESS	OF FACILIT	Balt		, Ma	ryland
with hours aft plately filled in by cremation, or remorement, the medical		23. PART i. Enter the diseases, of shock, or heert failur iMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	a. List only one ba	we on each	h line.	Les	e mode	of dylng	g, such e	cerdlec or resp	atonsv	ville et,	Maryland Approximate Interval Between Onset and Daati
Co. BOX 68 certificate be executed physician and Hygiene prior to bur other traumatte	CERTIFICATION	Sequantially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	С.		ONSEQUENCE O								
ORDS that the ored by the th and Me any injur	EDICAL	PART II. Other significant conditi	ons contributing to	deeth but	not resulting	in the unde	erlylng o	ceuse glv	en in Per	t i. 24e. WAS AN PERFOR	IMED3	C	PRE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
AL taw has b Dept.	2	DID TOBACCO USE CON	TRIBUTE TO CA		DEATH YE			UNCE	RTAIN [YES 2 THO
→ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	ER/Outpatie	ent 3 🗆 DOA	OTHER:	g Home	1101010	_	Other (Specify)			
O F si fi	ED BY PH	1 Natural 5 Pending 2 Accident investigation 3 Suicide e Could not be	(Month, C	Nay: 384/)	At home Jarrii, s	M	WORK WORK 4- YES	CP CP	мо	d. DESCRIBE HOW I			te Number,
DIN OR TOTAL DIRECT POURTS	COMPLETE	4 Homicide determined 29e. CERTIFIER Check only 1 CERTIFYING PHYONE) 2 MEDICAL EXAMI	SICIAN: To the best of NER: On the beels of a							he cause(a) and mar			nd manner as stated,
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	O BE CO	29b. SIGNATURE AND TITLE OF CERTIF	IER		· lot	< 5×11	2 Z	POTENCEN	SE NUMBER				fonth, Day, Year)
		30. NAME AND ADDRESS OF PERSON	F210 11	0556	- (fthe	Print)	ren	+ PI	Ey;	Colon	612,1	MOZ	21.44
		31. DATE FILED (Month, Day, Year) 400	32. PEGISTRA	S SIGNATU	JRAND A				17				/

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

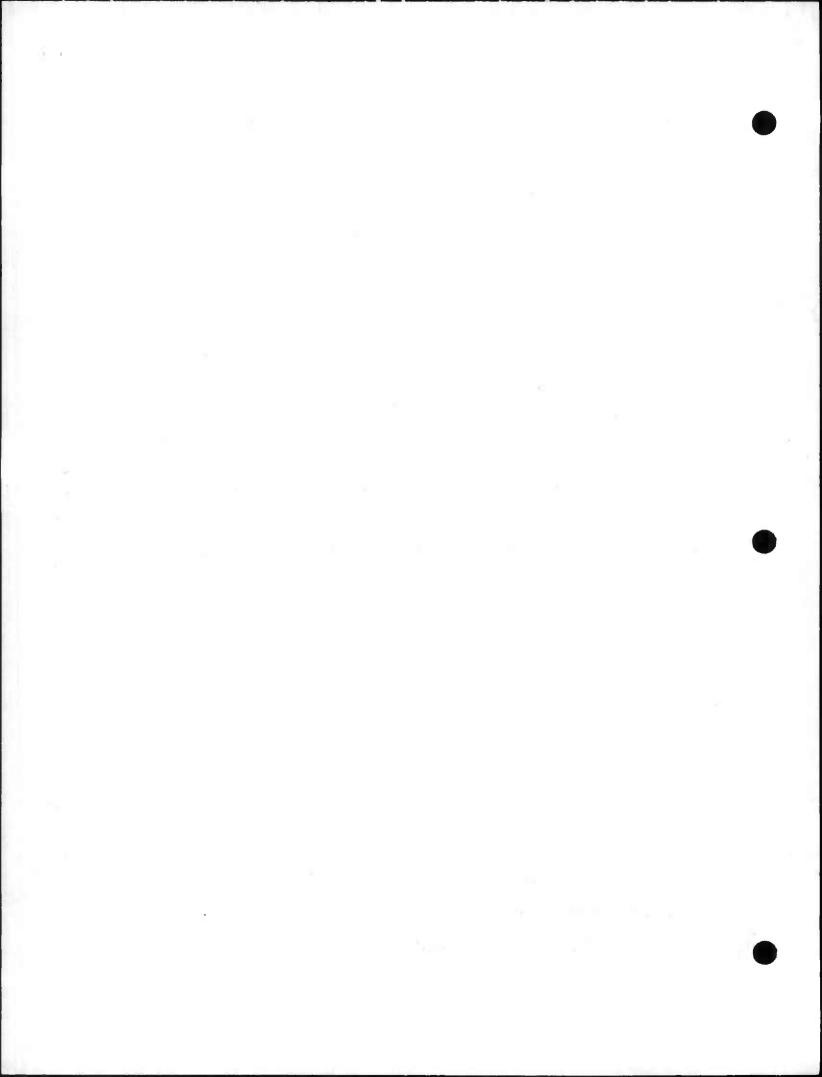
				O MATERIAL TO	IOAI	- 01				EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Idelle	andy					Dec. 6,1994 YEAR			YEAR	3. TIME OF DEATH 9:40 P		
		5 AEV											
	TO STATE OF THE ST	5. SEX 1 M 2 F		s. last birthday) 7 YRS.	MONTHS	DAYS	HOURS	24 HRS.	7. DATE OF E (Month, Da Feb, Of	иятн у. <i>Уваг)</i> Э. 189	7	Count	HPLACE (State or Foreign ry)
	9e. FACILITY NAME (If not institution, give stre	et and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY O								
OR	Maryland General	1 Hosa	Hospita	1			imore					N/A	
2	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY				Y, TOWN								
FUNERAL DIRECTOR	Maryland	N/A		10c. CIT			re Ci	ity					10d, INSIDE CITY LIMITS? 1 X YES 2 NO
A	10e. STREET AND NUMBER			101. ZIP CODE							10g. CiT	IZEN OF	WHAT COUNTRY?
KER.	2211 W. Rogers Ave						2	21209	9			U.S	S.A.
E	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	YES 2	X NO	13.	WAS DE	CENDENT C	F HISPAN	IIC ORIGIN? (S	pecify Yee	or No-	14, RACI Blac	E — Americen Indien, k, White, etc.
BY	3X Widowed 4 Divorced	S 2X NO Specify:					Spec						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/I												
PLE	Elementary/Secondary (0-12) College (1-4 or 5 +) iite. Do NOT use retired.) 8 years Homemaker Own Home												
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, Middl	e. Meiden :	Surnamel		
	John Nelson Norr	is							Dale Fo				
H	19a. INFORMANT'S NAME (Type/Print)	LD		195 MAIL INC	ADDRES	C /Ctreat			Route Number, C		Ctente 7	n Cadal	
2	Dorothy Sweeten												and 21042
	204. METHOD OF DISPOSITION		700 014	CEANDDATE				17.1					
İ	1X Buriel 2 Cremetion 3 Remov 4 Donation 5 Other (Specify)	val from Stale	cemetery	idon Pa	other place	Ceme	tery		DATE 20c. LOCATION - City or Town, State 12-9 Baltimore, Maryland				
	21. SIGNATURE OF FUNERAL SERVICE/LICE	NSEE			22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home								
	Sterral 1	erra	re									Mary	yland 21212
	23. PART I. Enter the diseases, or co	mplications that	caused the	daath. Do	not enta	r the me	oda of dy	ing, suc	h aa cardisc	or respir	atory ar	rest,	Approximate
	ahock, or heart fellure. LI IMMEDIATE CAUSE (Fine)	ist only one ceus	e on eech	line.									Interval Between Onset and Death
	disease or condition	Hype	rosm	olar.	No	nke	toti	c S	yndro	me			unknown
	reaulting in deeth) e.			NSEQUENCE O									
_				Mel1	,	S							
ō l	Sequentially list conditions, b.			NSEQUENCE O									+
¥	if any, leading to immediate cause. Enter UNDERLYING												
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A COR	NSEQUENCE O	F):								-
E	resulting in death) LAST												
빙	- a.												
EDICAL CERTIFICATION	PART II. Other algnificent conditions	contributing to	seeth but n	ot resulting	In the u	nderiyin	g ceuse g	given in	Part I. 24s	PERFOR		246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
얼Ⅱ									_ 1	YES 1			COMPLETION OF CAUSE OF DEATH?
MEI										7	777		1 TES 2 NO
	DID TOBACCO USE C	ONTRIBUTE	TO CA	AUSE OF	DEA	TH '	YES [I NC					
<u> </u>	25. WAS CASE REFERRED TO MEDICAL					26. P	LACE OF D	EATH (Ch	eck only one)				
S		HOSPITAL:	ER/Outpetter	nt 3 🗆 DOA	OTHE 4 Nu		ne 5 🗆 Be	eldence	6 Other (Sp	ecifu)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF I	NJURY	26b. TIN	E OF		JURY AT	Justice	28d. DESCRI	_	JURY OC	CURED	
2	1 Natural 5 Pending	(Month, Day	y, Year)	IN.	JURY		ORK? YES 2	NO					
B	2 Accident Investigation 3 Suicide & Could not be	26e. PLACE OF	INJURY - A	t home, farm.	atreet, fac			_	261. LOCATIO	N /Street a	nd Numbe	v or Rumi	Proute Number
COMPLETED	4 Homicide 6 Could not be determined	building, a	, , , , , , , , , , , , , , , , , , , ,						wn, State)	no mambo	01 (1010)	TOTA TOTAL	
ا ڌ	290. CERTIFIER 1 XCERTIFYING PHYSIC	IAN: To the best of r	ny knowledos	e death occur	and at the	lime date	e end place	and due	to the cause/s) and man	nor or sto	ted.	
ž I	earl .												a) and manner as stated
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month Day Mar)													
2	0 / 12-00-94												
	30. NAME AND ADDRESS OF PERSON WHO					Μ	1	J C	000 6 == =	1 11		+ - 1	
	Tatiana Moura				/0	mar	y ı an	a G	enera	T HO	sp1	.cal	
	DEC 1 2 1994	REALSTRAN	S SIGNATUR										

MANAGEMENT AND ASSESSMENT OF THE PARTY OF TH
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH												3. TIME OF DEATH		
	Robert Tho		dwin							Decemb	er S	Ö, 19	94	м
	4. SOCIAL SECURITY NUMBER 216-36-2019	BER	5. SEX	6. AGE (In yrs. Is	yrs.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF E	HRTH y, Year) 7 1	940	Countr	PLACE (State or Foreign y) yland
	9e. FACILITY NAME (If not in	stitution, give s	freet and number)			9b. CITY	, TOWN	OR LOCATE	ON OF DE		,,,		NTY OF D	<u> </u>
DIRECTOR	3206 Ryers		cle			Lan	sdov	vne				Bal	timo	re
EC	10e. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN C	OR LOCAT	TION						10d. INSIDE CITY
PIG.	Maryland	Balti	more		Lansdowne									LIMITS?
FUNERAL	3206 Ryerso		le.				101	2122					States	
ON C	11. MARITAL STATUS		12 WAS DECEDEN	IT EVER IN U.S. A	RMED	13.	WAS DEC			IIC ORIGIN? (S	pecify Yes			- American Indian,
BY F	1 Never Merried 2 💢 3 Wildowed 4 Divo		FORCES? 1	YES 2 X	NO	- 1	It yes, sp		n, Mexica	n, Puerto Ricar			Speci	
<u>B</u>	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working													
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive													
MO	Tr. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme)													
BE C	Alexander W. Godwin Gertrude A. Prince													
5	190. INFORMANT'S NAME (Type/Print) 190. INFORMANT'S NAME (Type/Print) 190. INFORMANT'S NAME (Type/Print) 190. INFORMANT'S NAME (Type/Print) 3206 Ryerson Circle, Lansdowne, MD 21227													27
	200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State													
	4 Donetion 5 Other	(Specify)		Cedar	Hil			ry 12	2/14	/94	Bro	oklyı	n Par	rk, Maryland
1	21. SIGNATURE OF FUNERA	L SERVICE LIC	PHISEE	0				NO ADDRE		cility 11 Home	. Ir	ic.		
	() coll	1016	~~	~		13	28 5	Sulph	ur S	pring	Řd.,	Arb	utus	, MD 21227
	23. PART I. Enter the di shock, or h	lseeses, or c eert fellure.	complications the List only one cau	t caused the duse on each lin	eeth. Do	not enter	the mo	de of dy	ing, suci	h as cerdiec	or respi	ratory er	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Fir disease or condition	nel	Medial	cho no	n Smanl	1 mA	200	TIA M	10 8	f lun				Onset end Death
	resulting in death)	3	Metast DUE TO	(OR AS A CONSE	EOUENCE O	F):	. (47	CINON	tot v	1011	5			16 MONTES
NO	Sequentially list conditi		b. DUE TO	(OR AS A CONSE	EQUENCE O	fi:								
CAT	if any, Isading to Imme- cause. Enter UNDERLYI CAUSE (Disease or Inju	NG	c		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
CERTIFICATION	that initiated eventa resulting in deeth) LAS	_	DUE TO	(OR AS A CONSE	OUENCE O	f):								
GE			1									_		_
EDICAL	PART II. Other significa	nt condition	s contributing to	death but not	resulting	in the ur	deriyin	g cause (given in	Part I. 24	PERFOR		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
EDIC										1[YES 2	₩ NO		OMPLETION OF CAUSE OF DEATH?
. M								_		-				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL						LACE OF D	EATH (Ch	eck only one)				
YSIC	1 TES 2 NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER		10 5X Re	sidence	8 Other (Sp	ecify)			
ву РН		Pending Investigation	28e. DATE OF (Month, E		28b. TIN	IE OF JURY M		IURY AT ORK? YES 2] NO	28d. DESCRI	BE HOW II	NJURY OC	CURED	
	3 Suicide 6	Could not be determined	28e. PLACE Coulding,	ome, term,	street, faci	ory, offic	•		281. LOCATIO City or To	N (Street e wn, State)	and Numbe	r or Rural F	loute Number,	
29e. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and menner as stated.														
COMPLETED) end manner es stated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIES	415					29c. LICI D36	ense nun	ABER				(Month, Day, Year) 12, 1994
1	30. NAME AND ADDRESS OF BERCO	PERSON WH	O COMPLETED CAU				اد دا	112						
	21 DATE Ell ED (Month One	Maci	32. REGISTRA	DIO DIONISTINO		KITC	1110	нīgh	way,	Pasad	ena,	Mar	ylan	d 21122
	DEC121	1994	Taki Davel	sor Rankal	4									





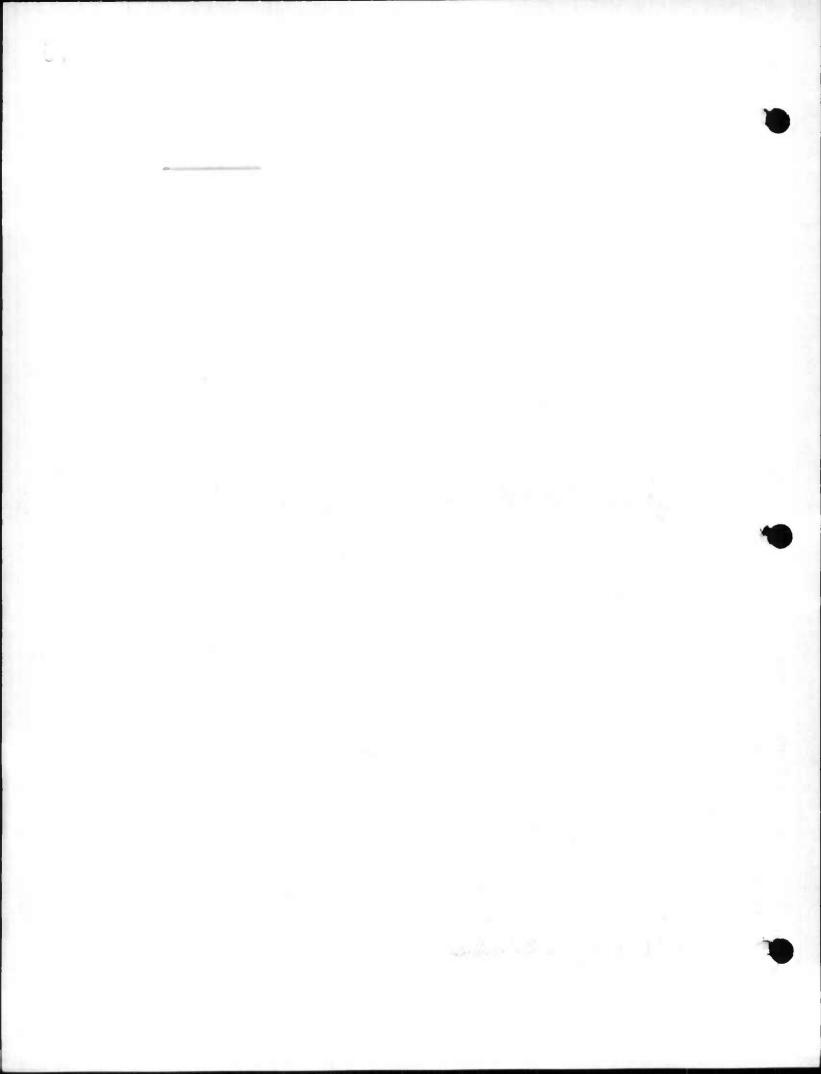
TO THE HOSPITA	TO THE FUNERAL	be filed within 72	SAMPONTALITY IS
1	TO THE	be filed	TO STATE OF
	1	/)

2

Item7, g-718, 12-16-94, perf.h., dr FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 426 AM AleyANA YEAR Halas 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 - F Country) permit, Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Merchan DIRECTOR Pattenisa RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Baltimore Halethorpe 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY burfal-transit -Incolr Avenue .S. A. 2122 after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Married If yes, specify Cuban, Maxican, Pr 1 YES 2 XNO Specify: IF YES, GIVE WAR OR DATES BY as the l 3 Widowed 4 Divorced Specify: HITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY page 5 should be detached for use (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Machinist notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surna Ha 19a, INFORMANT'S NAME (Type/Print) 0 M. la thorpe, MD 21227 INC Olo. 0 pe 20a METHOD OF DISPOSITION must 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION director, 2 Cre Cemetery Cathedral ☐ Donation 5 ☐ Other (Specify) Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES n by the funeral cremoval. 22. NAME AND ADDRESS OF FACILITY Funeral Home, Inc Arbutus, MD21227 Rd. Sulphur Spring 23. PART L Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, medicai filled in by Approximate shock, or haert failura. List only one causa on each lina. 0 Interval Batwean IMMEDIATE CAUSE (Finel completely filled rial, cremation, o the disease or condition resulting in death) OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within event. certificate has been signed by the attending physician and con h the State Dept, of Health and Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other i that initieted events reaulting in death) LAST 6 any injury, PART II. Other significent conditions contributing to death but not resulting in MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 23 shows a OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 Dinpetient 2 ER/Outpetient 3 DOA 5 27. MANNER OF DEATH with b 28a. OATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending DIRECTOR: After the hours after death v BY 1 YES 2 NO 2 Accident 99 3 Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 8 Could not be 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 28 4 Homicide item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion 29 SIGNATURE AND TITLE OF CONTIFIER BE 29d. DATE SIGNED (Month, Day, Ye 91

LETED CAUSE OF DEATH (TEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE



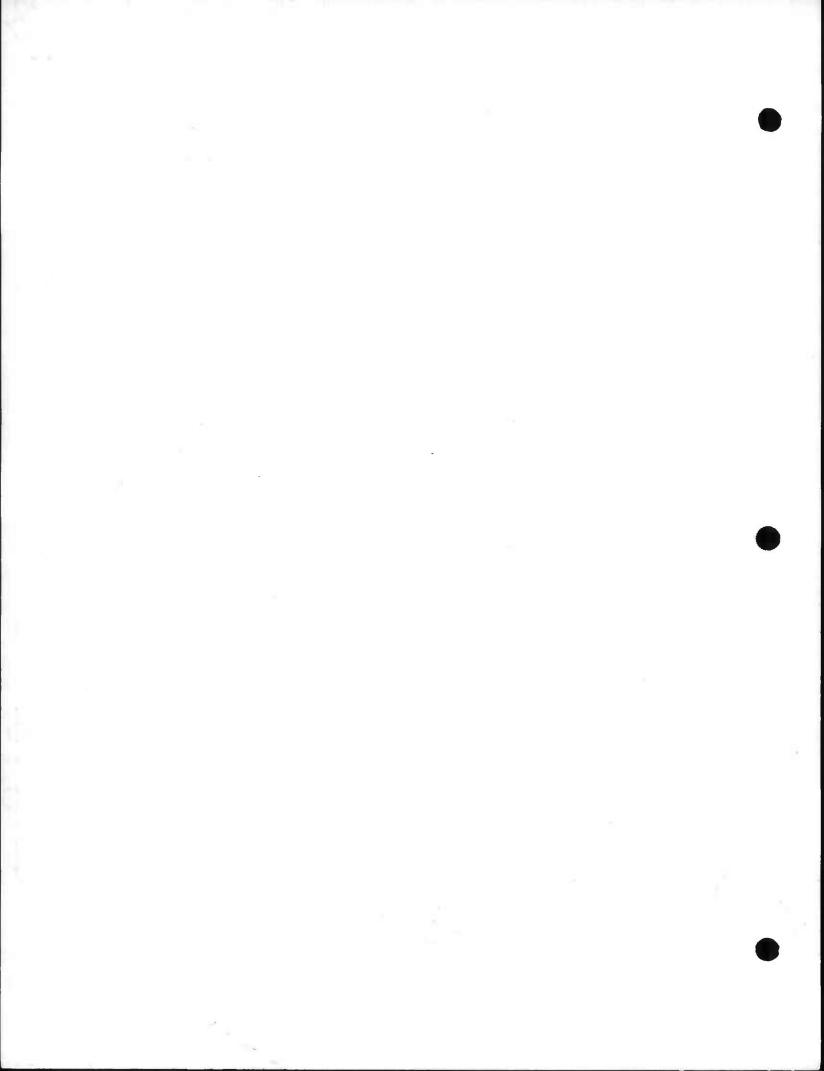
INTANT If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HISPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. HINETAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should warm 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE

	REGISTRAR		CE	RTIF	ICATE	OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	OF OEATH		MEAD	3. TIME OF OEATH
	MARY E.	HAVLICEK						Dec	_		994	5:10 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. las	t birthday)	IF UNDER 1		IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTI	IPLACE (State or Foreign
	217-05-8143	1 🗆 M 2 🛣 F	75	YRS.	MONTHS	BYAD	HOURS MIN.		6-191	9	MI	
ľ	9e. FACILITY NAME (If not institution, give	,			9b. CITY, T	O MWO	R LOCATION OF D				NTY OF D	
ECTOR	2006 Ewald <i>P</i>	Ave.			Du	ında	alk			B	alti	.more
5	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNT	rv		10- 017	V 701451 00							
HIG	100 miles	Ltimore		toc. CIT	Y, TOWN OR							10d. INSIDE CITY LIMITS?
- 11	10e, STREET AND NUMBER	rcimore			Du	_	ZIP CODE					1 TYES 2 X NO
FUNERAL	2006 Ewald A	Ave				101.	21222			10g. CI I	US	WHAT COUNTRY?
5	11, MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S.AR	MED	13. WA	AS DECE	NOENT OF HISPA	NIC ORIGI	N7 (Specify Yee	or No—	t4. RACI	E — American Indian,
À A	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 I		10			city Cuben, Mexic 2 X NO Speci		Rican, etc.)		Spec	white, etc. White
ETED	15. DECEDENT'S EDI (Specify only highest grad	UCATION is completed			USUAL OCC			168	. KIND OF BUS	INESS/IN	DUSTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	e retired.)	my mos	t or working					
COMPL	8			Home	make	r						
3	17. FATHER'S NAME (First, Middle, Last)	C = 0	0.0				16. MOTHER'S N					
N L	THOMAS	STRUF					AGN		MIF			
2	t90. INFORMANT'S NAME (Type/Print) Marie A. Pet						d Number or Rural					000
	204. METHOD OF DISPOSITION	erson	20b. PLACE				Ave.	Dun	dalk,		City or To	
	1 N Burlet 2 Cremation 3 Rar 4 Donation 5 Other (Specify)	noval from State	cemetery, cre	matory or of	ther place)	Me	morial					e, Md.
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	nead	0//		_	D ADDRESS OF F		19d Do	101	MOTE	e, Ma.
	anthony	Colt (m	ell	y S	on:	nelly 0 Soll	Fune	ral H	lome	of 212	Dundalk
	23. PART I. Enter the disease, or shock, or heart fall re-	complications that ca	used the de	ath. Do	enter th	ne mod	le of dying, au	ch aa can	diac or reapi	ratory ar	reat,	Approximate
	iMMEDIATE CAUSE (Final	List only one cause	on each line		5							Interval Between Onset and Death
- 1	disease or condition resulting in death)	· METAS	TAT	16	CAN	10+	n Ll	ANG	7			
	111 100 - 100 37 100 27	DUE TO (OR	AS A CONSEC	DUENCE OF	7):							
2	Sequentially list conditions,	b										
⋛∥	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSEC	JUENCE OF	·):							i
₹	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR	AS A CONSEC	UENCE OF	D:							_
CERTIFICATION	reaulting in death) LAST	4										!
3		0.										
₹	PART II. Other aignificant condition	na contributing to de	ath but not r	eauiting i	n the unde	eriying	cause given in	Part I.	24a, WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
<u> </u>	SEVENCE C	OFD			_				1 - YES 2	3/6		COMPLETION OF CAUSE DF DEATH?
Ĕ					V							1 - YES 2 - NO
HTSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUS		_			UNCERTAI	N 🗆				
3	EXAMINER?	HOSPITAL:			H'(Check onl		1/					
2 1	1 TYES 2 NO 27. MANNER OF DEATH	t Inpatient 2 ER		26b. TIM		g Home 8c. INJU	5 A Rasidence		77	I II III OO	CURE	
2	1 Natural 5 Pending	(Month, Day,)		INJ	URY	WOF	łK?	200. DE	SCRIBE HOW II	NJUHT OC	CORED	
6	2 Accident Investigation 3 Suicide & Could get be	26e. PLACE OF IN	JURY — At ho	me, ferm, s				28f. LOC	ATION (Street a	and Numbo	e or Aural I	Poute Number
3	4 Homicide 6 Could not be detarmined	building, atc.	(Specify)		,	,,			or Town, State)	ma real rico	or riorer i	todo Hambol,
MPLEIE	29a. CERTIFIER CERTIFYING PHYS	NOIAN. To the best of an										
Ē		ER: On the best of my										a) and manner as stated
3	299. SIGNATURE AND TUBLE OF CERTIFIE	-			ii, iii iiiy opii	mon, de			and place, en			
۱ I	1/1/whom	IMMAN	M)			29c. LICENSE NU	MBER	_	29d. DAT	E SIGNED	(Month Day, Year)
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE O	F DEATH (ITE	4 27) (Time	Print)		VIJ	100		- 1	010	7/014
	PENELOPE	SCOTT.	MI			. /	ROADU	14~		212	3 1	-
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S		/ /	J . J	, ,,	100/100	11.	-	100	7	-
	DEC1 2 1994	all Shuder	2.11									



requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 ATTENDING PHYSICIAN: HOSPITAL OR

signed by the

s certificate has been s th the State Dept. of Hi d, or Item 23 show

this c

DIRECTOR: After to hours after death v

THE HOSPITAL (THE FUNERAL DEFINATION TO THE POPTANT: If IN

TO THE HOSPITA
TO THE FUNERA
be filed within 7.

hours after item 28 Is

marked,

any

MEDICAL

PHYSICIAN:

BY

COMPLETED

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Items20b,20c 12-13-94 FilmG718 W,H.Per F/H 94 36617 Item # 1 Film # G 718 12-12-94 N.A. Per funeral home FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -**CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BARBRA Barbara 1994 8:10 HARVEY DEC EMBER 4 Рм 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign SEPT 26 DAYS HOURS Va 1 M 2 X F 54 40 West YRS. 214-38-1383 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH RECTOR Pages 1, 2, 3 1603 SPRAY COURT BALTIMORE 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? BALTO MD ō XXYES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? APT5 1603 SPRAY CT 21217 completely filled in by the funeral director, page 5 should be detached for use as the burial-transit U S.A 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried 2 K NO BY Specify: BLACK 3 Wildowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Widdle, Meiden Sumame RUDOLPH CALLIE CLOUD notified at RUBEN 띪 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or 2809 ELSINORE AVE BALTO MD 21216 2 L HARVEY CARA pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Burlel 2 Cremetion 3 Removal from State commetery cremetory of Star Cemetery 12-10 94 Catonsville, MD 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE a medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate shock, or heert fallure. Liet Dniy Dne ceuse Dn eech iine. interval Between IMMEDIATE CAUSE (Finei Onset and Death the disease or condition_ resulting in death) a. Arteriosclerotic Cardiovascular Disease event. the attending physician and con Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in death) LAST 0

AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5x73 Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending investigation М 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide

1 CERTIFYING PHYSICIAN: To the past of the knowledge, death occurred at the time, date end place, and due to the cause(e) end menner ee steted. (Check only one) 2 X MEDICAL EXAMINER: On the

PART ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert I.

tion end/pr investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

DECEMBER 5, 1994 O.C.M.E. OF DEATH (FTEM 27) (Type, Print)

MARIO D 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

24b. WERE AUTOPSY FINDINGS

24s. WAS AN AUTOPSY PERFORMED?

DECT 2 2004 Julia Armandadas

FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended for use as the burial-transit permit. Pages 1, 2, 3 should be attended for use as the burial-transit permit.

BALTIMORE, MARYLAND 21215-0020

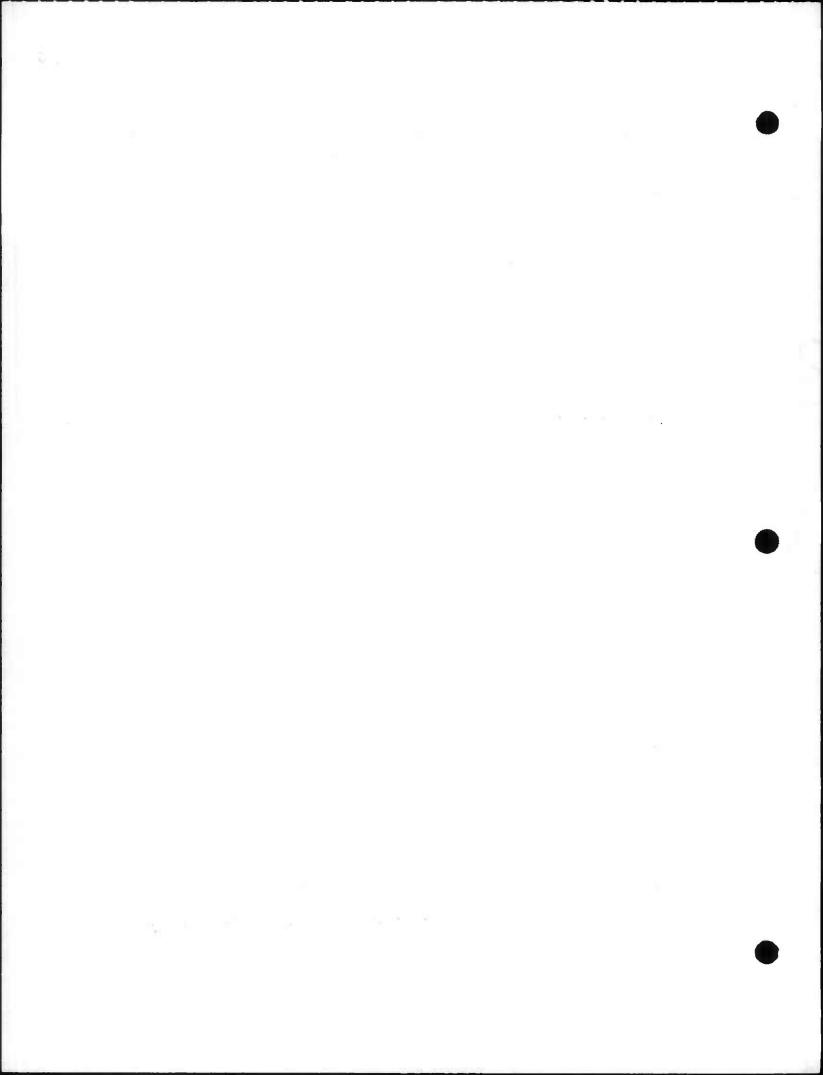
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

hours after death. Page 6 may be retained by the hospital or attending physician. MPOSTANT II Iem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ID THE HISPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAN				CERTIF	TOA	IE OI	PUEA	I H		REG. NO				
	1. DECEDENT'S NAME (First	, Middle, Last)							2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH						
	Christia	n			Herr	era				De			YEAR	0315 *	
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In y	rs. last birthday)		DER 1 YEAR	IF UNDES	R 24 HRS.	7. DATE	OF BIRTH		8. BIRT	HPLACE (State or Foreign	
	216-08-346	0	1 ∑ M 2 □ F		16 YRS.	MONTH	S DAYS	HOURS	MIN.		h, Day, Year) 24,	1978	Count	(17)	
	9a. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CI	ITY, TOWN	OR LOCATI	ION OF DI		6 271	_	NTY OF		
5	Charle Ma	7.1.m 5	Conhon			Ι,	D - 1 - 1								
5	Shock Tr	EDENT	Center			Baltimore									
DIRECTOR	10e. STATE	10b. COUNT			10c. CI	10c. CITY, TOWN OR LOCATION Ellicott City									
- 1	Maryland	ŀ	Howard			EL	LICOT	c C1	су				LIMITS? 1 YES 2 XNO		
A	10e. STREET AND NUMBER		- 1				101. ZIP CODE					10g. CIT	IZEN OF	WHAT COUNTRY?	
ᇤ	8508 High	Riage	e Road					2	1043				U.	S.A.	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.	S. ARMED	1	3. WAS DI	ECENDENT (OF HISPAI	VIC ORIGIN	17 (Specify Yes	or No-	14. RAC	E — American Indian,	
ВУ	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W				11 yes, 1	specify Cuba	sn, Mexica Specif	in, Puarto i y:	Rican, etc.)		Spec	k, White, atc.	
								Peru						White	
COMPLETED	15. DEC (Specify only	EDENT'S EDU y highest grade	CATION completed)	16	(Give kind of life, Do NOT	work dor	OCCUPAT	TION nost of worki	ng	16b	KIND OF BUS	SINESS/INC	DUSTRY		
۳	Elementary/Secondary (0	1-12)	College (1-4 or 5 +	+)							a1 m	7	. 1	2-11	
M P	11				St	uder	nt			_			igh i	School	
	17. FATHER'S NAME (First, M Alfredo He										Middle, Maiden	Surname)			
BE				_						. Yo					
2	190. INFORMANT'S NAME (1) Alfredo He		(Father	-)							ber, City or Tow			land 21043	
			Trachet						Jau .	_	_				
	20a. METHOD OF DISPOSITI	n 3 🗆 Ram	oval from State		ACE AND DATE TY. CTEMPSTORY OF STIAWN				1 4	DATE 20c. LOCATION — City or Town, State 94 Marriottsville Maryl					
	4 Donation 5 Other 21. SIGNATURE OF SUNERA		CHOSE	Cre	stlawn						Mar	rioti	CSV1	rie Marytano	
			5-4	4.				AND ADDRE			C Wit	zke I	Fune	ral Homes	
	Lucs	eud	my a	7			_							le Maryland	
	23. PART I. Enter the di	sesses, or	complications that	t caused th	e death. Do	not ent	ar the m	ode of dy	ing, suc	h as card	diac or raspi	ratory an	rest,	Approximate	
ı	shock, Dr haart fallure. List only Dna cause on each line. IMMEDIATE CAUSE (Final Glesse or condition														
l	disease or condition resulting in desth) a. /fcad unjuries														
	DUE TO (OR AS/A CONSEQUENCE OF):														
z	Consentativi list oppolitions b.														
윤	Sequantially list conditi if any, leading to imme-		DUE TO	(OR AS A CO	INSEQUENCE (DF):									
S	Cause. Entar UNDERLYI CAUSE (Disease or inju		C												
E	that initiated events resulting in death) LAS	·	DUE TO	(OR AS A CO	INSEQUENCE (P):									
H	resulting in death) LAS	' (d												
EDICAL CERTIFICATION	PART II. Other aignifica	nt condition	na contributing to	death but	not resulting	in the	underivi	ng cause i	given in	Part I	24a, WAS AN	ALITODEY	244	. WERE AUTOPSY FINDINGS	
8			•					ing cadao :	Arvair in		PERFOR		240	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
										-	1 YES 2	□ NO		OF DEATH?	
Σ	DID TORACCO II	CE CONITI	DIDLITE TO CA	LICE OF I	DEATH V	F6 🗆	1 200							1 → YES 2 □ NO	
AN	DID TOBACCO U 25. WAS CASE REFERRED TO		KIBUTE TO CA		PLACE OF DE				ERIAII	и ГП I					
PHYSICIAN:	EXAMINER?	J WEDICAL	HOSPITAL:			OTH		9)		-	_				
₹	1 YES 2 NO		1X Inpatient 2 28s. DATE OF				-	me 5 🗆 Re	esidenca						
	_	Pending	(Month, Di	ay, Year)	26b. TII	JURY	W	JURY AT	-10 T	~	CRIBE HOW I				
B	2 X Accident	investigation	12/8/	94	190	- /		YES 2 D	₫ NO		ER, OVE				
COMPLETED		Could not be determined	building,	atc. (Specify)	At home, ferm,		actory, off	Ice		28f. LOC City	ATION (Street a or Town, State)	WEST	FRIE!	Route Number,	
<u> </u>				R	BADWAY						AND BUP				
<u>e</u>			CIAN: To the best of												
Š.	one) 2 XMEDI	CAL EXAMINE	R: On the basis of a	nd/or Investigati	on, In m	y opinion,	death occur	red at the	time, data	and placa, en	d due to th	na cause(a) and manner as stated.		
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER	A .					29c. LIC	ENSE NU	ABER .		29d. DAT	E SIGNED	(Month, Day, Year)	
	Wonald.	4.W	right MI)		O.C.M.E.						▶De	C 1	0 1994	
٥	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	E OF DEATH	(ITEM 27) (Typ	e, Print)		· ·	الا م ب	<u>• 13 • </u>		De	· L	V 1274	
	DONALD G.	WRIGH	IT MD	1	111 P4	nn	Str	eet	Ra	1+in	nore	Mar	77] a	nd 21201	
	31. DATE FILED (Month, Day,		B2. REGISTRA	SIGNATH	IRE			- Labelog		الماسا	W. E.	Hall	ATG	IIV ZIZVI	
	UF U. I. Z. 199	4 XW	of this manager	mount											



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

	nsit permit. Pages 1, 2, 3 should		
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	INRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3	in 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	STANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
E HOSPITAL	E FUNERAL DIR	dywithin 72	FTANT: IF

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARY	AND / DEPAR Certif					E			
1. DECEDENT'S NAME (First, Middle, Last)		OLITTI	IOAIL	01 0	LAIII	REG. NO.		2 TIME	OF DEATH	
STER	LING ARNOL	D HERBST				MONTH DA	1994	YEAR		
The state of the s		(In yrs. last birthday)	IF UNDER 1		UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (S Country)	tate or Foreign	
215-03-1944	M 2 □ F	90- 80 YRS.	WOMINS.	DAYS HO	JUHS MIN.	Nov. 11,19	914	Connect	icut	
9a. FACILITY NAME (If not institution, give stree	t and number)		9b. CITY, 1	TOWN OR L	OCATION OF DE	ATH	9c. COUN	ITY OF DEATH		
Harford Gardens N	ursing Cen	ter	Bal	ltimo	re		~			
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40.00	Y. TOWN OR	1.0017:01						
		10c. C11						LIM	IDE CITY ITS?	
Maryland			Balt	imor					\$ 2 NO	
	2102 Count out A									
1XXNever Merried 2 Married	FORCES? 1 YES	2 NO	H:	yes, specify	y Cuban, Maxican	n, Puerto Rican, etc.)	or No-	14. RACE — Amer Black, White, a	can Indian, itc.	
3 Widowed 4 Divorced	WW TT	DATES	11	NES 2X	XNO Specify		- 1	Specify:		
15. DECEDENT'S EDUCAT	ION	16a. DECEDENT'S	USUAL OCC	CUPATION		16b. KIND OF BUS	INESS/IND	Whi	te	
(Specify only highest grade cor Elementary/Secondary (0-12)	npleted) College (1-4 or 5 +)	(Give kind of v	work done du se retired.)	iring most of	f working					
8 years		Inspe	ctor			Insura	ance	Company		
17. FATHER'S NAME (First, Middle, Last)				18.	. MOTHER'S NAI	ME (First, Middle, Maiden	Sumame)			
Frank Sebastian	Herbst				Emma I	ouise Nodi	ine			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and N	Number or Rural R	loute Number, City or Town	n, State, Zip	Code)		
Earl L. Herbst		2821	Emera	ald Re	oad, Pa	rkville, N	lary1	and 2123	34	
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove		b. PLACE AND DATE		ION (Name o	of	DATE 20c. LOC	CATION — C	Olty or Town, State		
4 Donation 5 Other (Specify)		Greenmou		cemat	ory	Bal	Ltimo	re, Mary	land	
21. SIGNATURE OF TUNERAL SERVICE LICEN	BEE	<u>ک</u>			ODRESS OF FAC	YTLIK	_			
James F. Burn	side Ir	71 '				lefeld, Hor				
23. PART I. Enter the diseeses, pr con		d the deeth. Do r	not enter ti	he mode t	ork Ros	d. Baltimo	retory em	MD_21212	proximets	
shock, or heart fellure. Lis	t only one cause on	eech line.					,	int	erval Between	
IMMEDIATE CAUSE (Finel disease or condition	Rodonia	1.0- to	0-	CT	1	- .			set and Death	
resulting in deeth) e	arterio. DUE TO (OR AS	A CONSEQUENCE OF	E):	ora	ryari	ery our	ins			
					(,		j		
Sequentially liet conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	F):		,				-	
cause. Enter UNDERLYING										
CAUSE (Diseese or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):							
resulting in desth) LAST										
PART II. Other significent conditions of	postellarities to de etc.			4.1.		1				
	sortic as			eriying cs	suse given in i	Part I. 24s. WAS AN. PERFOR		AVAILABL	TOPSY FINDINGS E PRIOR TO	
- Inchaece	and an	enger.		. 7.		1 YES 2	□ NO	OF DEAT	TION OF CAUSE 17	
Caroue do	Here	a juen	ava	-/-	sedde			t 🗌 YES	2 🗌 NO	
DID TOBACCO USE CONTRIB	SUIE TO CAUSE C				UNCERTAIN					
EXAMINER?	OSPITAL:	28. PLACE OF DEAT	OTHER:							
27. MANNER OF DEATH	☐ Inpetient 2 ☐ ER/Out	petient 3 L DOA 26b. TIM		6c. INJURY		6 Other (Specify) 26d, DESCRIBE HOW IN	I II IEW OOD	VIDEO		
1 Natural 5 Pending	(Month, Day, Year)		URY	WORK?	2 NO	200. DESCRIBE NOW I	JUNI OCC	OHED		
2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJUR	Y — At home, farm, s	street fector		2 🗆 110	261. LOCATION (Street a	nd Alumbar	or Pural Boute Num	har	
4 Homicide 6 Could not be	building, atc. (Spe	cify)		,, 0		City or Town, State)	na reamber	OF FIGHT FIGHT	,,	
29a. CERTIFIER	N. To the board of	ded a second	7074	1 III - 112		III. S = - Constant				
anal	N: To the best of my know								- Francis	
2 MEDICAL EXAMINER: (on the basis of standard	AT SHOULD HIVESTIGSTIC	a, ai my opi				g due to the	cause(s) and mar	ner as stated.	
296. SIGNATURE AND TITLE OF CERTIFIER	0. "			290	c. LICENSE NUM		29d. DATE	SIGNED (Month, D	ay, Year)	
Mary Ch	neceporte	Mis			8240	20	7 /2	2-9-74		
30. NAME AND ADDRESS OF PERSON WHO C				Dool	D-1-4	more Mass	.1	21227		
Marion C. WKowal			TOLG	noad	, Dalil	more, Mary	rand	21234		
1 9 1004	A STRUCTURE NO	retall								

Item # 18 FOR 1 G 718 N.A.
1 - STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN HILKER , JR. EDWARD 12 8:20 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 218 09 4343 (Month, Day, Year) 03 15 20 1X M 2 - F 74 DAYS HOURS YRS. Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATN Hopkins Bay View Medical Center DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Md. Baltimore City 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 5000 East Biddle Street burial-transit 21205 USA Page 6 may be retained by the hospital or attending physician, al director, page 5 should be detached for use as the burial-trar 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married BY 3 🗌 Widowed 4 🔲 Divorced W.W. 2 White 16a. OECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY (Give kind of work done during lile. Do NOT use retired.) ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) Shingle Factory Fork Lift Operator COMPL 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Hilker, Sr. Marie Marie notified at Ziolkowska BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Pauline Hilker 5000 East Biddle Street Balto., Md. 21205 90 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must the funeral director, cemelery, crematory or other place;
Sacred Heart of Jesus Cem. 12-13-94 Dundalk, Md medical examiner 22. NAME AND ADDRESS OF FACILITY
Charles S. Zeiler & Son Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ours after death. 901 S. Conkling St. Balto., Md. 23. PART i. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreet, filled in by **Approximata** shock, or heart feilurs. List only one cause on each line. intarvai Between 0 **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition and completely fi o burial, cremation SEPSIS SYNDROME OUE TO (OR AS A CONSEQUENCE OF): 4 days resulting in death) event. 10 days BACTERIAL PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditiona, prior to if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): thet initiated events signed by the attending Health and Mental Hygie resulting in deeth) LAST PART II. Other aignificent conditione contributing to death but not resulting in the underlying ceues given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL any CEREBRAL VASCULAR DISEASE, HYPONATREMIA, 1 YES 2 NO OF DEATH? URINARY TRACT INFECTION 1 TYES 2 P NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specily) 10 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED marked, INJURY 1 Naturel 1 YES 2 NO ВУ After t 2 Accident Investigation 26s. PLACE OF INJURY — At home, farm, streat, factory, office building, stc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 18 6 Could not be DIRECTOR: / after c COMPLETED 4 Homicide tem OR 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. THE HOSPITAL OF THE FUNERAL D Ξ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) 29c. LICENSE NUMBER B 95010 12/10/94 0 WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARKHAM C, LUKE JOHNS HOPKINS BAYVIEW, 4940 Eastern MUE B.H.M. MO 31. DATE FILED (Month, Day, Year)

Per Funeral Home 12-12-94

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

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BE 2 (Check only one)

DEC1 2 1994

Violet Mae Howal 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 218 22 2795 HOURS 1 M 2 X YRS. Pages 1, 2, 3 should 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 7840 Water Oak Point Road DIRECTOR Pasadena RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION Maryland Anne Arundel Pasadena permit 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 7840 Water Oak Point Road Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 21122 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TES 2 NO Specify BY 3 Widowed 4 Divorced COMPLETED 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5 +) Assembly Worker 3rd once. 17, FATHER'S NAME (First, Middle, Last) 76 Clyde Ryden BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Ray Smith 116 Otis Drive pe 20s. METHOD OF DISPOSITION
1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must funeral director. Glen Haven Hemorial Park 4 Donation 5 Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. Ritchie Hwy. and completely filled in by the burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final testal disease or condition resulting in death) injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): prior to burial. CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate attending physician cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated eventa Hygiene DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST The atten Mental 1 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL A DE shows any Signed Hearth a 1000 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN has to Dept 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Certificate h them HOSPITAL 1 YES 2 NO tlant 2 - ER/Outpetient 3 -4 Nursing Home marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? the contract of Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28 is COMPLETED 4 Homicide detarmined FUNNEY TIRES

CAUSE OF DEATH (ITEM 27

Shucker Rangell

001

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

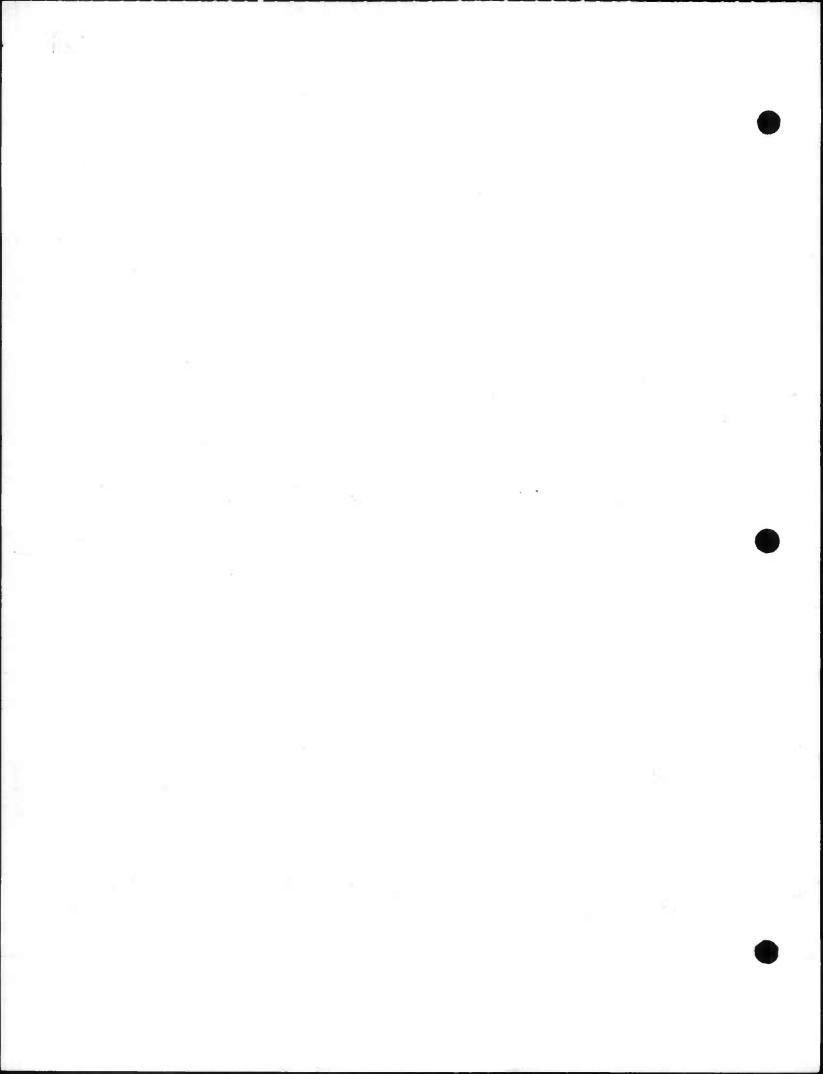
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

94 36621

3. TIME OF OFATH

2. DATE OF DEATH YEAR December 1994 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) April 22 West Vinginia 19 9c. COUNTY OF GEATH Anne Arundel 10d. INSIDE CITY 1 YES 2 NO 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. White 16b. KIND OF BUSINESS/INQUSTRY Glass Factory 18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown Severn, Maryland 21144 DATE Glen Burnie, 12/10 22. NAME AND ADDRESS OF FACILITY - GEORGE J. GONCE FUNERAL HOME P.A. Baltimore, Md. 2/225 Approximate Interval Between Onset and Death 2 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO Rasidence 8 - Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. CENSE NUMBER 29d, DATE SIGNED



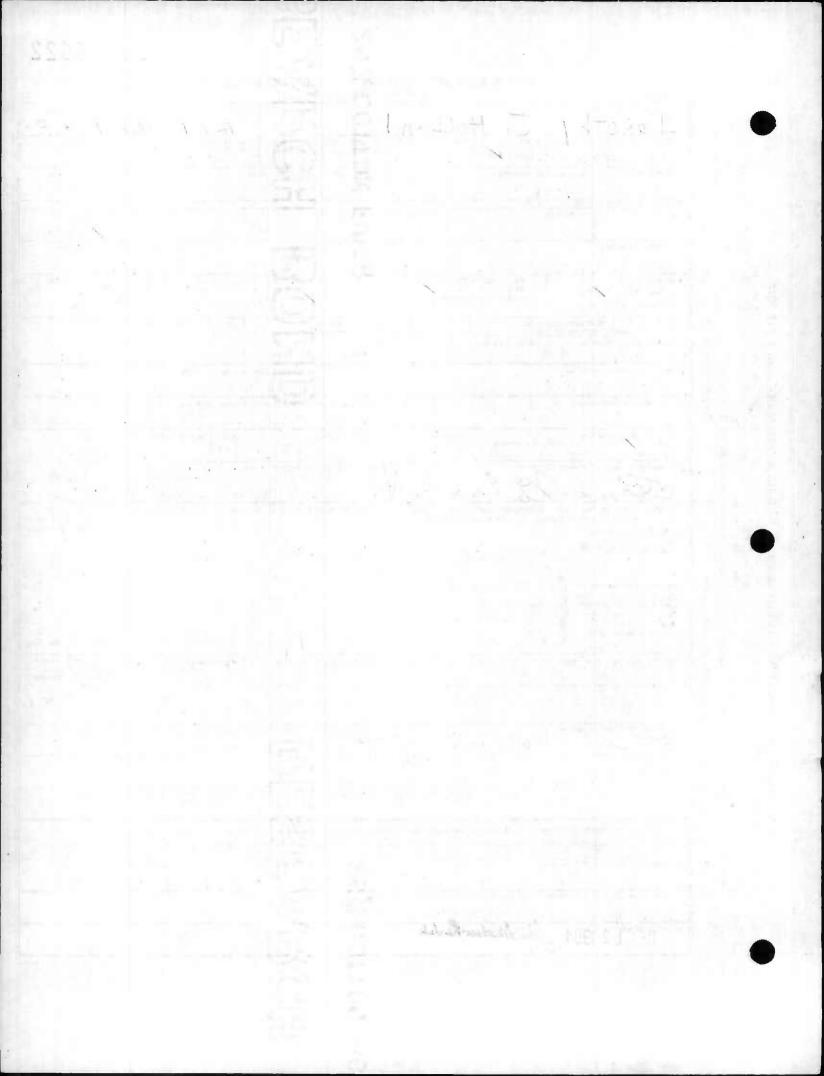
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OROT Hollan 194 : 10 P 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH A. BIRTHPLACE (State or Foreign 6/27/30 213-28-9996 1 M 2 FF MD Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Church Hospital Baltimore City 10b. COUNTY 18c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD 1 YES 2 NO Baltimore City permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 2308 E. Baltimore St. 21224 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Guban, Maxican, Puerio Rican, stc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, alc. 215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced White ETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe pol Elementary/Secondary (0-12) College (1-4 or 5+) COMPL detached Unk. Unk. Housewife once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) 2 Joseph Moravec Christina Charvat BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Paul Holland 2308 E. Baltimore St. Baltimore, MD 21224 pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Greenmount Cemetery 12/5 Baltimore, MD 4 Donation 5 Other (Specify) B. Dabrowski & Son Funeral Home examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dema 2818 E. Baltimore St. Baltimore, MD 21224 n by the f medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory street, abock, or haert failure. List only one causa on each line. illed in by Intervsi Between ripletely filled in cremation, or r **Onset and Death** IMMEDIATE CAUSE (Finsi the disease or condition resulting in death) Lespirator Facture event, DUE TO (OR AS A CONSEQUENCE OF): to burial, o COPI traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if sny, lesding to immediate cause. Enter UNDERLYING inding physician a CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in death) LAST the attending p 0 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL and and shows any COMPLETION OF CAUSE signed by Health a 1 YES 2 NO OF DEATH? 1 TYES 2 T NO t, of h PHYSICIAN: has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h HOSPITAL: OTHER: 1 YES 2 NO 1 Propertient 2 ER/Outpetient 3 DOA E HOSPITAL DR ATTENDING PHYSICIAN: E FUNERAL DIRECTOR: After this certifica d within 72 hours after death with the St. ATANT: It item 28 is marked, or It 4 Nursing Home 5 Residence 6 Other (Specify) DIVISION OF V 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c, INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, larm, street, lactory, offica building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined COMPLETED 4 Homicide 29s. CERTIFIER

//Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE mo 20 Thin -1 - 26594 12/1/1994 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 100 N. Broadway Baltimore, MD 21231 Bodhan 1 2 DASSAGE CONTEST



be notified at once.

examiner must

medical

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event,

or other traumatic

Injury.

23 shows any

marked, or item

IMPORTANT: If Item 28 is

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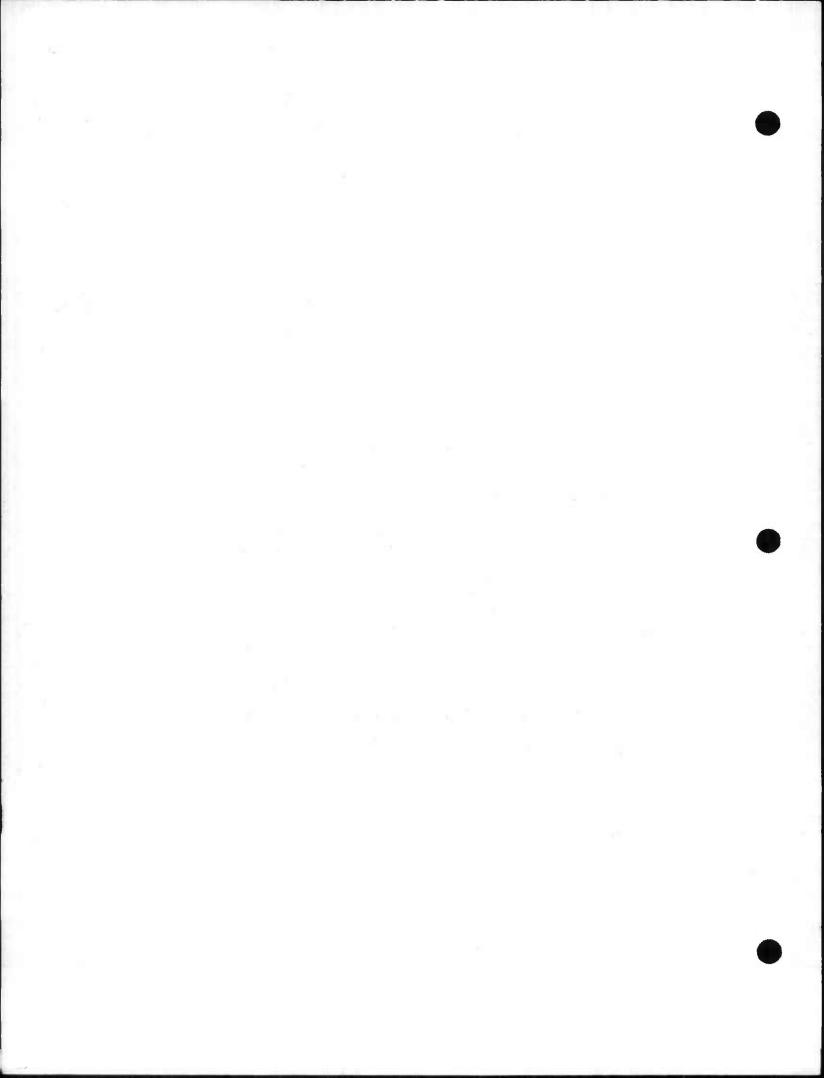
permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ar frouns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit of	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
101	5	De fil

94 36623 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 9 YEAR Villa Jackson 08 2145 A M mae 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 296-38-7860 50 HOURS 1 - M 2 F Ma Ohio YRS. 9b. CITY, XOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Iniversity DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION
But He 10b. COUNTY 10d. INSIDE CITY ma 10 1 YES 2 NO 3634 FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21207 U.S.A Dres 0 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.)
 T YES 2 Y NO Specify: 14. RACE — American Indian, Black, White, arc. 1 Never Married 2 Married 3 Divorced Black BY COMPLETED 15. OECEDENT'S EOUCATION 16s. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high dary/Secondary (0-12) 2 4rs ZK Charities atholic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Earnest Wal Callauril-Wa BE 9a. INFORMANTAS NAME (Type) 2 METHOD OF DISPOSITION Burial 2 Cremation 21. SIGNATURE OF FUNERAL SE 23. PART i. Enter the disea shock, or heert IMMEDIATE CAUSE (Final diseese or condition resulting in death) COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in deeth) LAST PART ii. Other significent o Renal Failure, greenants, Probab DID TOBACCO 25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2

				11-(4001)	- 1
190. INFORMANTIS NAME (Type/Print) Meridith	Jacksun 3	21 211 V	est and Number or Rural Ro	Rd Balto	mnd 21207
20s_METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 6 Other (Specify)	from State 20b PLACE company_cre	AND DATE OF DISPOSITION		DATE 200 POCATION - CH	y or Town, Stata
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	22, NAME	ANO ADDRESS OF FACI	IUTY /	
► Blady	Warren	s p	arch f.	H-West ash Are	
	pilcetions that ceused the de t only one ceuse on each line	ath. Do not enter the	mode of dying, such	as cardiec or respiratory arres	interval Between
iMMEDIATE CAUSE (Final disease or condition resulting in death)	Continued he	northage			Onset and Deeth
Sequentially ilst conditions,	DUE TO (OR AS A CONSECTION OF A	ovence of:	whole sec	5.'\	19+days Unknown
PART II. Other significent conditions or Renal Failur, Candida greenenta, Probable alvest DID TOBACCO USE CO	e 500 hay it's, elem whemas shage, bilat	ted right hem; was subdurat hea	disiphaga, prol	PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL				KW.	
EN ASSISTED	OSPITAL: Unpatient 2 - ER/Outpatient 3	OTHER:	PLACE OF DEATH (Chec		
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	M 1	WORK? YES 2 NO	28d. DESCRIBE HOW INJURY OCCUI	RED
3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY — At he building, etc. (Specify)	me, tarm, street, factory, o	iffica	28f. LOCATION (Street and Number or City or Town, State)	Rural Route Number,
				o the cause(s) and manner as stated. me, data and place, and due to the c	
29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUME	BER 29d. DATE S	HGNED (Month, Day, Year)
Spenon 3, Marin	0,40		AU 4176-	435 Acz144 > 17	18/94
Souncer 5. Harhow	OMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)			
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE				
DEC1 2 1994 Julia	Caucher Ranket				OUNTY 48 B 400
					OHMH-16 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH FREDERICK JOH P. M. DECEMBER 10, 1994 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 215-30-8691 Nov 27, 193 DAYS 1xx M 2 □ F HOURS YRS 61 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FALLSTON DIRECTOR GENERAL HOSPITAL FALLSTON HARFORD RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Baltimore 13 YES 2 NO permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 420 Nottingham Road burial-transit 21229 USA Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-trar 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 → XYES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuben, Mexicen, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried BY Specify 3 Widowed 4 Divorced white 16e. DECEDENT'S USUAL OCCUPATION G 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ᆸ Elementary/Secondary (0-12) Coffege (1-4 or 5+)
16 +4 COMPL Engineer Electrical 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Frederick C. Joh. Sr. Eva P. Schmid notified at 8 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
420 Nottingham Road, Baltimore, Md. 21229 9 Gladys Joh pe 20e. METHOD OF DISPOSITION
1. Burlel 2 Cremetton 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must funeral director, Cametery, cremetory or other place)
Loudon Park Cemetery Donation 5 Other (Specify) 12/14 Baltimore, Md. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home ours after death. 101 736 Edmondson Avenue, Baltimore, Md. and completely filled in by the 1 b burial, cremation, or removal. 23. PART I. Enter tha diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or haart failure. List only one cause Interval Between IMMEDIATE CAUSE (Finel Onset and Death the Condiavascular disease or condition_ ullusclustie resulting in deeth) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) Descire CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leeding to immediate the attending physician Mental Hygiene prior to cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events other QUE TO (OR AS A CONSEQUENCE OF) resulting in deeth) LAST 5 PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY Health and N shows any 1 TYES 2 NO OF GEATH? 1 TYES 2 NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WUNCERTAIN I has by Dept. DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) Item EXAMINER?

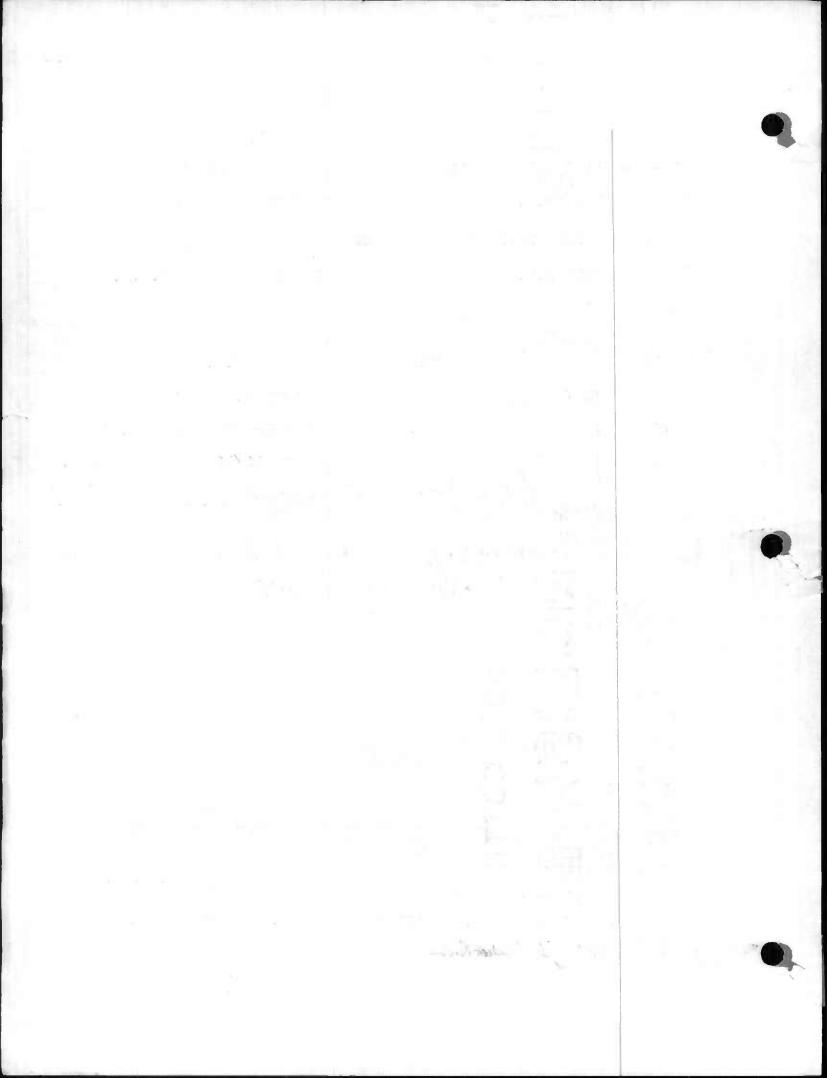
1 O YES 2 NO

27. MANNER OF DEATH DIRECTOR: After this certificate hours after death with the State HOSPITAL: Inpetient 2 ER/Outpe DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 1 Netural
2 Acciden 1 YES 2 NO BY Accident Investigation 26e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 649 COMPLETED 8 Could not be 4 Homicide 28 determined Tem 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) and manner as stated. TO THE HOSPITAL OF THE FUNERAL COMPOSED FOR THE FUNERAL COMPOSED FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR THE FOR opinion, death occured at the time, date and place, and due to the cause(e) and manner so stated. ALLES MILLS 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCME MUD hi M simble 2 OMPLETEO CAUSE OF OEATH (NEM 27) (Type, Print) 31. DATE FILED (Morith, Day, Year)
DEC 1 2 1994 HEGISTRAR'S SIGNATURE

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68766,
BOX
P.O.
RECORDS, I
OF VITAL RI
IVISION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the HOSPITAL OF HERBAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cramation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest) CHARLES N.	JOHNSON				2. DATE OF DEATH DO NOTH DEATH	AY C	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 235-36-5637	1x M 2 □ F 7	3 YRS.	F UNDER 1 YEAR ONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) 09 25	21	MAR	YLAND	
OR	9a. FACILITY NAME (If not institution, give 108 GREENWAY RESIDENCE OF DECEDENT				N BURNI		9c. COUNTY OF DEATH ANNE ARUNDEL			
DIRECTOR	10s. STATE 10b. COUNT	Y 10c. CITY, TOWN OR LOCATION IE ARUNDEL GLEN BURNIE					10d. INSIDE CITY LIMITS? 1 1 YES 2 X NO			
	10e. STREET AND NUMBER	101. ZIP CODE					AT COUNTRY?			
FUNERAL	108 GREENWAY				21061			U.S.A.		
B	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYPES GIVE WAR OR DO NOT THE WAY 11	2 NO	If yes, spi	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specifityes, specify Cuban, Maxican, Puarto Rican, etc. 1 YES 2 NO Specify:			y Yes or No— 14. RACE — American Indian Black, White, etc. Specify: WHITE		
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 8 +)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use	k done during mo	DN et of working	16b. KIND OF BU	SINESS/INC	DUSTRY		
MPL	12	04	SUPERV	ISOR		U.S.G		NMEN'	T	
8	17. FATHER'S NAME (First, Middle, Leet) CHARLES H. J(OUNIC ONT				ME (First, Middle, Malder				
BE	19a, INFORMANT'S NAME (Type/Print)	DHNSON	19b. MAILING A	DDRESS (Street a		J V. WRIC		p Code)		
2	JANIS FARR			1.000		-VENTURA		111	93003	
	20e METHOD OF DISPOSITION 1 \(\text{D} \) Burlel 2 \(\text{Cremation} \) 3 \(\text{Rer} \) Rer 4 \(\text{Donation} \) Donation 6 \(\text{Other (Specify)} \)	noval from State of	D. PLACE AND DATE COMPLETE COM			12/12 GI		City or Tow		
	21. SIGNATURE OF FUNERAL SERVICE L		Iman	22. NAME AF	D ADDRESS OF FA					
	23. PART I. Enter the diseases, of	complications that caused List only one cause on e	the death. Do no						Approximata Interval Between	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Amyoli	ophic	Late	ral &c	Lecon	1		Onset and Death	
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL (PART II. Other eignificant condition	na contributing to death b	out not resulting in	the underlyin	g cause given in		N AUTOPSY ORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
PHYSICIAN: MEDIC						1 YES	2 XNO		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO N/A	
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. P	ACE OF DEATH (Ch	eck only one)				
PHYSI	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Year)		OF 28c. (N. W)	TURY AT DRK? YES 2 NO	6 ☐ Other (Specify) 28d. DE\$CRIBE HOW	INJURY OC	CCURED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)				281. LOCATION (Street and Number or Flural Floure Number, City or Town, State)			oute Number,	
COMPLETED	CONNECTION AND ADDRESS OF THE PARTY OF THE P	SICIAN: To the best of my know IER: On the besis of examination							and manner as stated.	
BE	29b. SIGNATURE AND TITLE OF CENTER	audorne			29c. LICENSE NUI	30 T		2/08	(Month, Day, Year) /94 .	
5	30. NAME AND ADDRESS OF PERSON W	PINENI M.I			AL DR.	GLEN BUR	NIE,	MD.	21061	
	DEC1 2 1994	32. REGISTRAR'S SIGN	NATURE							



94-7159-510

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. TO BE COMPLETED BY FUNERAL DIRECTOR BALTIMORE, MARYLAND 21215-0020 IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ITEMS: 23 PART I, 27,	. 28a-f. PER MEO	FILM G-	722 4/15/	95 t.1			94	30	0626
1 - FOR STATE REGISTRAR	STATE OF MARYLAND		MENT OF HI		MENTAL	HYGIENE REG. NO.			
1. OECEDENT'S NAME (First, Middle, Lest) MEYERS			JOHNS	ON	2. DATE OF MONTH	DAY		/EAR	TIME OF OEATH
4. SOCIAL SECURITY NUMBER 220-36-0021	8. AGE (In yrs. In		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	() { F BIRTH Day, Year)		94] BIRTNPLA Country)	2:25 P
90. FACILITY NAME (If not institution, give stree JOHNS HOPKINS H		9		LOCATION OF DE		4	9c. COUNT	Y OF DEATH	Carolino
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10e CITY	TOWN OR LOCATION					40.4	I, INSIDE CITY
Maryland 100. STREET AND NUMBER		Bal	Himo	Ce				1)	YES 2 NO
718 Cotor A	NC.		101.	211212			Am	N OF WHAT	COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. AFFORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES	RMED NO		NOENT OF HISPAN lify Cuben, Mexice NO Specify	n, Puerto Ric		or No.— 14	Black, Wi	American Indien, nite, etc.
15. DECEDENT'S EDUCAT (Specify only highest grade core Elementary/Secondary (0-12)	mpleted) (G	CEDENT'S US	SUAL OCCUPATION for done during most retired.)	of working	16b, K	IND OF BUSE	NESS/INDUS	STRY	AC IY
17. FATHER'S NAME (First, Middle, Lest)	Johnson	Sr	-	16. MOTHER'S NAI	ME (First, Mid	idle, Meiden S	(Q.))	
190. INFORMANT'S NAME (Type/Print) HOLON JOHNS	300	118	Cate	Number or Rural F	Pal	City or Town.	State, Zip C	217	212
20e, METHOD OF DISPOSITION 1 Shurlel 2 Commation 3 Remove 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	f from State	imatpry or other	DISPOSITION (Nav	Park	12/H	* Pa	HO.	y or Town,	d.
Dernik	C. Jan	~	461 18cm	LHeir	E.J	Ones	Fit	4,	2125
23. PART i. Enter the diseases, or conshock, or heart failure. Lis IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	DUE TO (OR AS A CONSE	1	cocai					t,	Approximate interval Between Oneet and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR AS A CONSE								
that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF):							
PART II. Other algolificant conditions of	contributing to death but not r	esulting in	the underlying	cause given in i	Part i. 2	4a. WAS AN A PERFORM YES 2	ED?	CDA	RE AUTOPSY FINDINGS LABLE PRIOR TO APLETION OF CAUSE DEATH? YES 2 \(\text{NO} \) NO
DID TOBACCO USE CONTRIB			Oheck only one)	UNCERTAIN	10			1	
EXAMINER? 1 XYES 2 NO	OSPITAL: inpatient 2 ER/Outpatient 3	_ 0	THER:	5 Reeldence	8 🗆 Other (S	Specify)			
27. MANNER OF OEATH 5 Pending investigation	28e. OATE OF INJURY (Month, Day, Year) UNKNOWN	286. TIME C INJUR UNKNO	Y WOR	(? VV		ECT ING			
3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — At he building, etc. (Specify)	me, ferm, atre	et, factory, office		281. LOCATI City or UNKNO	ION (Street an Town, Stete)	d Number or	Rural Route	Number,
	N: To the best of my knowledge, de On the beste of exemination end/or				to the cause	(e) end mann			557 - 54.
29b. SIGNATURE AND TITLE OF CERTIFIER	. III	veaugarion, l		th occured at the t					oth, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF GEATH (ITE	M 27) (Type, Pri	int)	O.C.M.	Ε.		▶ DE	C 9,	1994

Penn Street, Baltimore, Maryland 21201

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should use as the burial-transit permit. ay be retained by the hospital or attending physician. page 5 should be detached for use as the burlal-tran # notified hours after death. Page 6 may be pe must funeral director, examiner n by the removal. medicai filled in by 0 event, the completely executed wil and com traumatic 2 attending physician antal Hygiene prior to the death certificate be other 6 the atten Mental F and bre requires that any signed b shows been to 1 has b HOSPITAL OR ATTENDING PHYSICIAN: The law 23 this certificate h 10 marked, After t 60 DIRECTOR: 28 item FUNERAL within 72 t = TO THE HOSPITA
TO THE FUNERA
De filed within 7.

Bunners

32. REGISTRAR'S SIGNATURE

31. DATE FILEO (Month, Day, Year)

Item # 9c.17 Film # G 718 12-12-94 N.A. Per Funeral Home FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH KAISER 1994 DONALD DEC 1922 4. SOCIAL SECURITY NUMBER 6. BIRTHPLACE (State or Foreign Country) 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN 176 32 3100 1 M 2 - F 64 11/30/1930 <u>Pennsylvania</u> 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF CEATH 9c. COUNTY OF OEATH JANY OF MD. Brown Doc DIRECTOR BALTE MUNEZ RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Baltimore 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 307 Seward Avenue 21225 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puerlo Ricen, stc.)
1 ☐ YES 2 ☑ NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 X Merried Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. OECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION. 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer 12th Coast Guard 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 0 Robert J. Kaiser Bernice M. Gaskind BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 307 Seward Avenue Baltimore, Maryland 21225 Elfriede C. Kaiser 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1 X Burlet 2 Cremation 3 Removal from State
4 Donellon 5 Other (Specify) Cedar Hill Cemetery 12/12 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. liome mamuowski 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART i. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failura. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition Peru Brand 56 Houng resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 56 Hours FIBRILLARON VENTRICULAR O Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING CERTIFICAT PERMENS 56 Hours TRANSLUMINA Comman ANGROPLASTY CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST DIAME WITH COMPLICATION; Angeny Comvam PART II. Other aignificant conditione contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY MEDICAL 1 ☐ YES 2 ☐ NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Sympatient 2 ER/Outpatient 3 DOA 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCUREO 1 | Natural 5 Pending Investigation t YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end manner as attend. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE DEL DUBOIT 9 1994 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type Print) MD. 225, transmit

DHMH-16 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO

- 0	1. DECEDENT'S NAME (First,	Middle, Last)			02			027		2. DATE	OF DEATH			3. TIME OF DEATH	
	Carroll Jos	seph K	evs							MONT	H D/		YEAR	10.15 D M	
- 8	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs	. last birthday)	IF UNDE	IF UNDER 1 YEAR IF UNDER 24		24 HRS.	Dec. 10		TH 8. BIF		10:15 P M	
	216-20-8311		1 😡 M 2 🗌 F	68	YRS.	MONTHS	DAYS	HOURS	MIN.	(Monti	4, 19	26	Count		
1	9e. FACILITY NAME (If not in	stitution, give st	reet and number)			9h CIT	V TOWN	OR LOCATI	ON OF DE		7, 17	9c. COUNTY OF DEATH			
œ	1002 Downton	_	ŕ				,, , , , , , , , , , , , , , , , , , , ,			LAIT			alti		
8	RESIDENCE OF DEC							_			В	атіт	more		
DIRECTOR	10e. STATE	10b. COUNTY	10c. CIT	TY, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?			
	Md	Ват	timore	_									1 YES 2 NO		
AL	10e. STREET AND NUMBER						10	. ZIP COD	_			10g. CIT		WHAT COUNTRY?	
FUNERAL	1002 Downton	n Koad						212	27				USA		
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S	ARMED	13.	WAS DE	ENDENT (OF HISPAN	VIC ORIGIN	i? (Specify Yee Ricen, etc.)	or No-	14. RAC	E — American Indian, k, While, etc.	
ВУ	1 Never Merried 2 3 Widowed 4 🔀 Divo		WW TT					2 X NO			ween, etc.)		Spec	ity:	
		EDENT'S EDUC		1.0		<u> </u>								hite	
1	(Specify only	highest grade	completed)		Give kind of iife. Do NOT u	work done	during me	ON ost of working	ng	16b.	. KIND OF BUS	INESS/IN	DUSTRY		
7	Elementary/Secondary (0	-12)	College (1-4 or 5	•)		rvis					Garme	nt			
COMPLETED	17. FATHER'S NAME (First, Mi	iddle, Last)						16 MOT	HED'S NA	ME (Elect)	Middle, Malden				
Ö	George Keys											Surrierre)			
BE	George Keys Mildred Long 196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
2	George Keys										ore, M		2122	7	
	20g, METHOO OF DISPOSITI		7 T. 1. 77 T. 1		CEANDDATE					DATI	DATE 20c. LOCATION — City or Town. State				
	1 Buriel 2 Cremelio 4 Donalion 5 Other		rval from State	Gar	rison	Forrest Veterans 12/14 Owings Mills, Md.								s. Md.	
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE			22.									
	► \A4.00.	M X	Trul.			- 1		_			uneral			241 01000	
	23. PART i, Enter the	easea, or c	omplications tha	t caused the	death. Do	not enter	36 E	dmon	don suc	Aveni	ue, Ba	Ttim	ore,	Md. 21228	
	shock, or heart failure. List only one cause on each line. Interval Batween Onset and Death														
	disease or condition	aı	M	her a beautiful	, (, , ,	11	ii 1.			01				6 month	
ŀ	reaulting in death)		DUE TO	(OR AS A CON	ISEQUENCE O	-11 CC P):	1(()	7	DONC					6 Mary	
z	Sequentially list conditions b.														
CERTIFICATION	Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF):														
2	cause. Enter UNDERLYING CAUSE (Disease or Injury C.														
	CAUSE (Disease of Injury that Initiated events resulting in death) LAST														
5	d														
	PART II. Other algnifica	nt conditions	contributing to	death but n	ot resulting	In the u	nderlyln	g cause (given In	Part I.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS	
EDICAL						, , , , , , , , , , , , , , , , , , , ,					PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
							,				160 2	da ido		OF DEATH?	
N N	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF D	EATH Y	ES IV	NO F	UNC	ERTAIN					,	
¥	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)														
Sign	EXAMINER? 1 YES 2 NO		HOSPITAL:	ER/Oulpatien	t 3 🗆 DOA	OTHE	R: sing Hon	6 5 D Re	eldence	6 🗆 Other	(Specify)				
PHYSICIAN:	27. MANNER OF DEATH		26e. DATE OF (Month, D		28b. TIN	_	28c. INJ				CRIBE HOW IN	JURY OC	CURED		
BY		Pending nvestigation	(-y, 104.7		М		YES 2	NO						
	3 Suicide 8 🗌	Could not be	26e. PLACE O building,	F INJURY — A	t home, ferm,	street, fec	lory, offic	•		28f. LOCA	ATION (Street a	nd Number	r or Rural F	Route Number,	
	4 Homicide	letermined													
2		FYING PHYSIC	CIAN: To the best of	my knowledge	, death occurr	ed at the t	ime, date	and place	, end due	to lhe ceu	se(e) end men	ner ee sta	ted.		
COMPLETED	one) 2 MEON	CAL EXAMINER	t: On the beele of e	amination end	or investigation	on, In my o	plnlon, d	eath occur	red at the	time, date	end place, end	due to th	ne ceuse(e	e) end menner ee stated.	
ш	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICE	ENSE NUM	ABER	T	29d. DAT	E SIGNED	(Month, Day, Year)	
ω	In Ot	tani	MI)					D	408	50		•	1	2/94	
2	30. NAME AND ADDRESS OF				ITEM 27) (Type	, Print)							,		
) YVONNE		AU, ANU		O CAT	on	AU	E B	ALT	MM	ze n	an	21	229	
	DECT 2 195	(bar)	32. REGISTRA	R'S SIGNATUR	E										
	116119700	4/1 (h.)	IA diluction	Madell											



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

3 PHYSICIAN: The law requires that the death certificate be executed within 24-durs after death. Page 6 may be retained by the hospital or attending physician.) THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacted for use as the burial-transit permit. Pages 1, 2, 3 should	IN WITH THE STATE DEPT. OF HEARTH AND MEHICAL DISPLETED THIS TO DUTING, CHEMICALLY	arked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the d	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the	be filed within 72 hours after death with the State Dept. Of Hearth and Mel	IMPORTANT: It item 28 is marked, or item 23 shows any injur

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2 1994

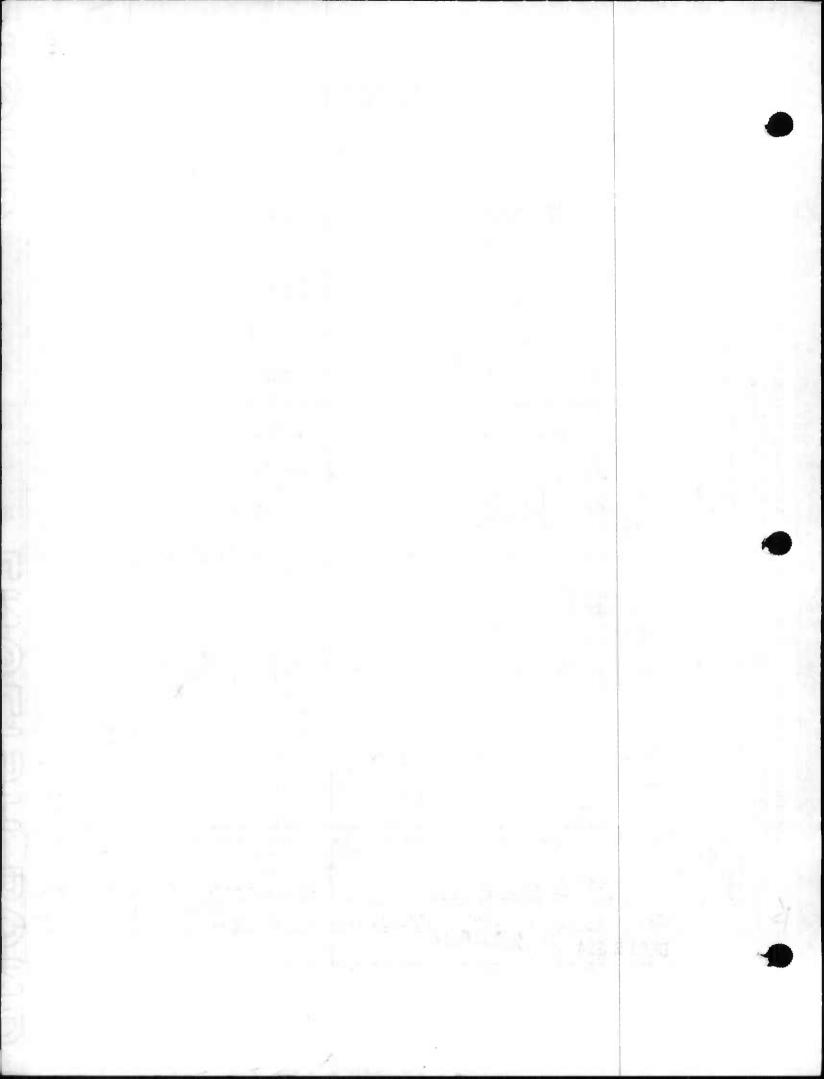
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TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
1. OECEOENT'S NAME (First	, Middle, Last)					3R		OF OEATH			TIME OF OEATH		
WILLIA	7 M	LOU	15	KI	REL	CER	MONTH	ZEC	110	YEAR	239/		
4. SOCIAL SECURITY NUME	DER 5. 5		8. AGE (In yrs. In	nt birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.		ACE (State or Foreign					
215-12-2892	1.5	X M 2 □ F	86	YRS.	THE DAYS	HOURS MIN.	MIN. November 19,1908 Maryland						
Se. FACILITY NAME (If not in	nstitution, give atreet	and number)		9b	CITY, TOWN	OR LOCATION OF OEATH 9c. COUNTY OF DEATH							
Manor Care,	Ruxton				Towson	1			Balt	imor	e County		
10e. STATE	10b. COUNTY			10c. CITY, TO	OWN OR LOCAT	rion				10	d. INSIDE CITY		
Maryland	Baltimo	re Cour	nty	Balti	imore					1	YES 2 X NO		
10e. STREET AND NUMBER					- v	. ZIP COOE			10g. CITIZE	N OF WHA	T COUNTRY?		
714 Overbro	ok Road					21212				U.S	.A.		
11. MARITAL STATUS		WAS DECEDENT	EVER IN U.S. A	RMEO		ENDENT OF HISP			or No- 1	4. RACE -	American Indian,		
1 Never Merried 2	1000	FORCES? 1	YES 2 X	NO		ecify Cuban, Mexic 2 NO Spec		lican, etc.)		Specify:	Thite, etc.		
3 Widowed 4 Divo	proed					A	,				Mhite		
15, DEC	EDENT'S EDUCATION	ON ofeted)		ECEDENT'S USL			16b.	KIND OF BUS	INESS/INDU	STRY			
Elementary/Secondery (T	ollege (1-4 or 5 +	1/4	. Do NOT use re		or working					100		
7	-		Tr	uck Med	chanic			Constr	ructio	n			
17. FATHER'S NAME (First, M	fiddle, Last)			=======================================		18. MOTHER'S N	NAME (First, M	fiddle, Meiden	Surname)				
George Mich	ael Krel	ler				Mary (NMI) S	Schaec	h				
19e. INFORMANT'S NAME (Type/Print)		11	b. MAILING AD	DRESS (Street	and Number or Rurs	al Route Numb	er, City or Town	, State, Zip C	Code)			
William Lou	is Krell	er. Jr.		418 Dur	nkirk l	Road, Ba	altimo	re. Ma	rylar	nd 21	212		
208 METHOD OF DISPOSIT	TION	014-3	20b. PLACI	E AND DATE OF	DISPOSITION		DATE	_	CATION - C				
1 X Burlel 2 Crematic 4 Donation 5 Other		from State	Dulan	ey Val	Ley	Dec	. 15	Luth	nervi]	le,	Maryland		
21. SIGNATURE OF FUNERA	SERVICE LICENS	EE () A			22. NAME A	ND ADDRESS OF	FACILITY						
	/ //	K. ()				chell-Wi							
1	merus !	1 Jan									nd 21212		
23. PART I. Enter the dishock, or h	liseeses, or comp neart fellure. Liet				enter the mo	ode of dying, su	uch as card	lisc or respi	ratory srre	at,	Approximats interval Between		
IMMEDIATE CAUSE (FI		Harris - Const				-0	1	1	4		Onset and Death		
disesse or condition_ resulting in death)	→ .	61	4RC	INO	MA	0/	41	VE	K.		1M.		
reconning in county		OUE TO	(OR AS A CONSI	QUENCE OF):									
	_ b					/							
Sequentisity that condition if any, leading to imme		DUE TO	(OR AS A CONSI	QUENCE OF):									
cause. Enter UNDERLY CAUSE (Disease or Inju													
that initiated events		DUE TO	(OR AS A CONSI	QUENCE OF):									
resulting in death) LAS	d												
PART II. Other signific	ent conditions co	ontributing to	death but not	resulting in t	he underlyin	a cause given	in Part i	24a, WAS AN	ALITOPSV	24h W	ERE AUTOPSY FINDINGS		
						g could give in		PERFOR	MED?	A	MILABLE PRIOR TO OMPLETION OF CAUSE		
								1 YES 2	™ NO		F DEATH?		
										1	YES 2 NO		
25. WAS CASE REFERRED 1 EXAMINER?		OSPITAL:		10	26. P	LACE OF OEATH (Check only on	10)					
1 TYES 2 NO			ER/Outpetient	3 DOA 4	ursing Hor	ne 5 🗆 Realdenc	e 8 🗆 Other	r (Specify)					
27. MANNER OF OEATH		28a. DATE OF (Month, D.	INJURY ny, Ybar)	28b. TIME O		JURY AT ORK?	28d. DES	CRIBE HOW I	NJURY OCC	URED			
1 Netural 5 2 Accident	Pending Investigation				M 1 🗆	YES 2 NO							
3 Suicide 8	Could not be	28e. PLACE O building,	F INJURY - At I	ome, farm, stre	et, factory, offi	00		ATION (Street or Town, State)	and Number	or Aural Aou	te Number,		
4 Homicide	determined							,					
290. CERTIFIER 1 CER	TIFYING PHYSICIAN	N: To the best of	my knowledge, o	leath occurred a	rt the time, dat	e end place, end d	tue to the cau	use(e) end mai	nner ee state	d.			
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. One) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ee stated.													
2 7 MED					n my opinion,	death occured at t	the time, date	and place, en	d due to the	ceuse(e) e	nd manner ee stated.		
2 MEL	DICAL EXAMINER: O				in my opinion,			and place, en					
2 T MET	DICAL EXAMINER: O				in my opinion,	29c. LICENSE N			29d. DATE	SIGNED (A	nd manner ee stated. North, Day, Year)		

CAUSE OF DEATH (ITEM 27) (Typa, Print)
Dr. TOWSON MA. 21204 H. GHILADI.

OHMH-16 Rev 1/89



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DIVISION OF VITAL RECORDS, P.O. BO

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the floath. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be field within 72 hours after death with the 2state Dept. of the that and Merital Hygline point to burial, cremation, or removal. INDIGITALLY If them 28 is marked as items 2 showe and him to another transmitted examples account the marked as items 2 should be accounted by the property of the pro	THE CHARLES IN THE PARTY OF THE	IMPORTANT. II NEIN 20 18 HOLLAND, OT NEIN 23 SHOWS ANY HIGH J. OTHER DEVINED STEIL, HIS INSURED AT DELICE.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN										
	1. DECEDENT'S NAME (First, Middle, Last)	Charles Ne		-		2. DATE OF DEATH NONTH DAY YEAR December 8, 1994										
	4. SOCIAL SECURITY NUMBER 5		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	BIRTHPLACE (State or Foreign									
	215-30-3947	× 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	YRS.	IONTHS DAYS	HOURS MIN.	Nov. 16,1934 Maryland										
	9a. FACILITY NAME (If not institution, give street	et and number)		96. CITY, TOWN (OR LOCATION OF E		9c. COUNTY									
DIRECTOR	66 Yorkway Dundalk Bail															
H.	10e. STATE 10b. COUNTY	Deltimous	10c. CITY,	TOWN OR LOCAT		-		10d. INSIDE CITY								
ā	Maryland	Baltimore			Du	undalk		1 YES 2 (NO								
FUNERAL	10e. STREET AND NUMBER	OF WHAT COUNTRY?														
ÿ	66 Yorkway	ited States														
5	11. MARITAL STATUS 1 Never Married 2 Merried	2. WAS DECEDENT EVER IN FORCES? 1 X YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	ANIC ORIGIN? (Specify Yesen, Puerio Ricen, etc.)		RACE — American Indian, Black, White, etc.								
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	rES		2 NO Spec			Specify:								
	15. DECEDENT'S EDUCAT	TON	44 - DECEDENTIA			1		White								
COMPLETED	(Specify only highest grade con	mpleted)	16a. DECEDENT'S US (Give kind of wo life. Do NOT use	rk done during mo	on st of working	16b, KIND OF BU	SINESS/INDUST	rry								
7	Elementary/Secondary (0-12) (College (1-4 or 5+)				Local	Union	#24								
M	17. FATHER'S NAME (First, Middle, Last)		Master	Electri		AME (First, Middle, Meiden		11								
	Robert Kincaid						Sumame)									
B	190. INFORMANT'S NAME (Type/Print)		19h MAILING A	DDDESS (Street a		thy Coster	- 00-1- 71- 0	**								
2	JoAnn Kincaid					Dundalk, Ma										
	20e. METHOD OF DISPOSITION	205.5	PLACE AND DATE OF				CATION — City									
	1 Donation 5 Other (Specify)	trom State ceme	tery, cremetory or other	r place)	Corr 1	2/12/94 To	TOOM - City	Monara I and								
	21, SIGNATURE OF FUNERAL SERVICE LICEN	SEE .	TITUP 3	22. NAME AP	ID ADDRESS OF F	ACILITY	wson,	Maryrand								
	Dohnun L. H.	illa				neral Home										
-	V 01.50			7922	Wise Ave	e. Dundalk	, Mary	land 21222								
	23. PART I. Enter the classes, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, ehock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) 8. January Course of Contract of the mode of dying, such as cerdiac or respiratory errest, interval Between Onset and Death															
	DUE TO (OR AS A CONSEQUENCE OF)															
Z	Sequentially list conditions b. A.S. C. V. D															
Ĕ	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):															
CERTIFICATION	CAUSE (Disease or Injury															
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST															
E	d															
Ar.	PART il. Other aignificant conditions c	ontributing to deeth bu	t not resulting in	the underlying	ceuse given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS								
MEDIC						1 TES	1-1	OF OBJECTION OF CAUSE OF OBJECTION OF CAUSE								
¥								1 YES 2 NO								
	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTA	IN 🗆										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	8. PLACE OF DEATH	(Check only one)												
YSI	1 - YES 2 1 NO 1	☐ Inpatient 2 ☐ ER/Outpat			e 5 🗆 Residence	8 Cher (Specify)										
표	27. MANNER OF DEATH 1 Maturel 5 Pending	(Month, Day, Year)	28b. TIME (URY AT RK?	28d. OESCRIBE HOW	NJURY OCCURE	EO								
BY	2 Accident Investigation				ES 2 NO											
	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY - building, atc. (Specif)	– At home, farm, str (/)	et, tactory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, and due to the cause(s) end menner es stated.															
2	(Check only one) 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner es stated. MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner es stated.															
		On the beals of exemination	end/or investigation,	in my opinion, u	ann occorde at the	- 11110, 0210 0110 p1000, 21										
	one) 2 MEDICAL EXAMINER: C	On the beals of exemination	end/or investigation,	m my opinion, u				GNED (Month, Day, Year)								
H	29b. SIGNATURE AND THILE OF CERTIFIER	Ros														
	one) 2 MEDICAL EXAMINER: C	Ros	TH (ITEM 27) Three Pi	rint)	29c. LICENSE NU		29d. OATE SIG	GNED (Month, Day, Year)								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. lours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

FUNERAL DIRECTOR

TO BE COMPLETED BY

									91	4 3	6631
Item#1,10k FOR 1 - STATE REGISTRAR	,10d	STATE OF MAR	RYLAND	H. Fi	MENT OF	-718 12 HEALTH AND F DEATH	/12/ MENTA		M . E		
1. DECEDENT'S NAME (First, Mic	idle, Lest)	JENNIFER				DEATH		REG. NO		3.	TIME OF DEATH
Jennis	2-R	Kins	17 1.4	NE KI	14 G		MON'	1 / -	7/	YEAR	00200 H
4. SOCIAL SECURITY NUMBER		5. SEX 6.	AGE (In yrs.	last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.		OF BIRTH		8. BIRTHPL	ACE (State or Foreign
213-52-7783	3	1 - M 2 F	32	YRS.	ONTHS DAY	B HOURS MIN.		th, Day, Year)	62	Country	ARYLAND
9a. FACILITY NAME (If not institution, give street and number) Sinai Hosgital Balto Md										INTY OF DEAT	
RESIDENCE OF DECED	ENT b. COUNTY			To see							
md	TE	Balto Ci	+	10c. CITY,	TOWN OR LO	CATION BALTIMORE	3			10	INSIDE CITY LIMITS? YES 2 NO
100. STREET AND NUMBER	791 271	1	0		T	101. ZIP CODE 2 1	208			IZEN OF WHA	T COUNTRY?
1442 6	reen	priar	Ci	nele		212	18		4	154	
11. MARITAL STATUS		12. WAS DECEDENT EV FORCES? 1	ER IN U.S	ARMED	13. WAS [ECENDENT OF HISP	ANIC ORIGI	N? (Specify Yes	or No-	14. RACE —	American Indian, Vhita, stc.
1 Never Married 2 Mar 3 Widowed 4 Divorced		IF YES, GIVE WAR		2110		Specify Cuban, Maxk ES 2 NO Spec		ricen, etc.)		Specify:	white
15. DECEDE (Specify only hig	NT'S EOUCA		18a.	OECEDENT'S U	SUAL OCCUP	ATION most of working	16	b. KIND OF BU	SINESS/INI	DUSTRY	
Elementary/Secondary (0-12)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	College (1-4 or 5+)	7	He. Do NOT use	retired.)	RESENTAT]	IVE	MEDIC	AT. CI	UPPLIE	ic.
17. FATHER'S NAME (First, Middle	, Lest)			0.22.(1.2.	013 1651	18. MOTHER'S N	_			OF FILTE	.5
DR. WALTER	BRADL	EY KING, S	JR.				LORE			EICKER	,
19a. INFORMANT'S NAME (Type/	Print)			19b. MAILING A	DDRESS (Stre	et and Number or Rura					,
MRS. DOLORES	S	KING				E AVE. BA					
20a. METHOD OF DISPOSITION 1 Burlel 2 □ Cremation		al from State		EAND DATE OF	DISPOSITION		OA.			City or Town,	State
4 Donation 5 Other (Spe 21. SIGNATURE OF FUMERAL SE		NOSE A		BETH T			12+9-	94 I	BALTI	MORE,	MD
- allen	xu	- Leur	na	(2)		LEVINSON		ROS.,	INC.		
23 PART i Enter the disease	202 07 00	molications that ca	unad tha	doub Do no	<u> 1601</u>	REISTER	STOW	N ROAD	BALI	IMORE	
IMMEDIATE CAUSE (Final	fallure. Li	st only one cause	on each iii	ne.			ch as csr	diac or respi	ratory an	reat,	Approximate Interval Batween Onset and Death
disease or condition resulting in death)	a.	HV AI	DS AS A CONS	NFEY	STION						
											İ.
Sequentially list conditions if any, leading to immediate		DUE TO (OR	AS A CONS	EQUENCE OF):							
cause. Enter UNDERLYING CAUSE (Disease or injury	c .										
that initiated events reaulting in death) LAST		DUE TO (OR	AS A CONS	EQUENCE OF):							
rounting in douting Error	d.										
PART il. Other algnificant o	conditiona	contributing to dea	th but not	reauiting in	the underly	ing cause given in	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS AILABLE PRIOR TO
								1 TYES 2	□ NO	CC	MPLETION OF CAUSE DEATH?
											YES 2 NO
DID TOBACCO USE		BUTE TO CAUS	E OF DE	ATH YES	□ NO	☐ UNCERTA	IN 🗆				
25. WAS CASE REFERRED TO ME EXAMINER?		HOSPITAL:	28. PL	ACE OF DEATH	(Check only or	10)					
1 TES 2 NO		☐ Inpetient 2 ☐ ER/	-	3 🗆 DOA 4	☐ Nursing H	ome 5 🗆 Raaldenca	8 🗆 Oth	er (Specify)			
27. MANNER OF CEATH		26a. DATE OF INJU	IRY	28b. TIME	OF 28c.	NJURY AT	28d. DE	SCRIBE HOW I	YJURY OC	CURED	

1 Natural

5 Pending investigation 2 Accident 3 Sulcide 6 Could not be determined 4 Homicide

28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

М

1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 ___ MEDICAL_EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

OF CERTIFIER 29c. LICENSE NUMBER

SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) 2 1994

29a. CERTIFIER (Check only one)

30. NAME AND A

32. REGISTRAR'S SIGNATURE Dendon-Randall

OHMH-16 Rev 1/89

and the state of t

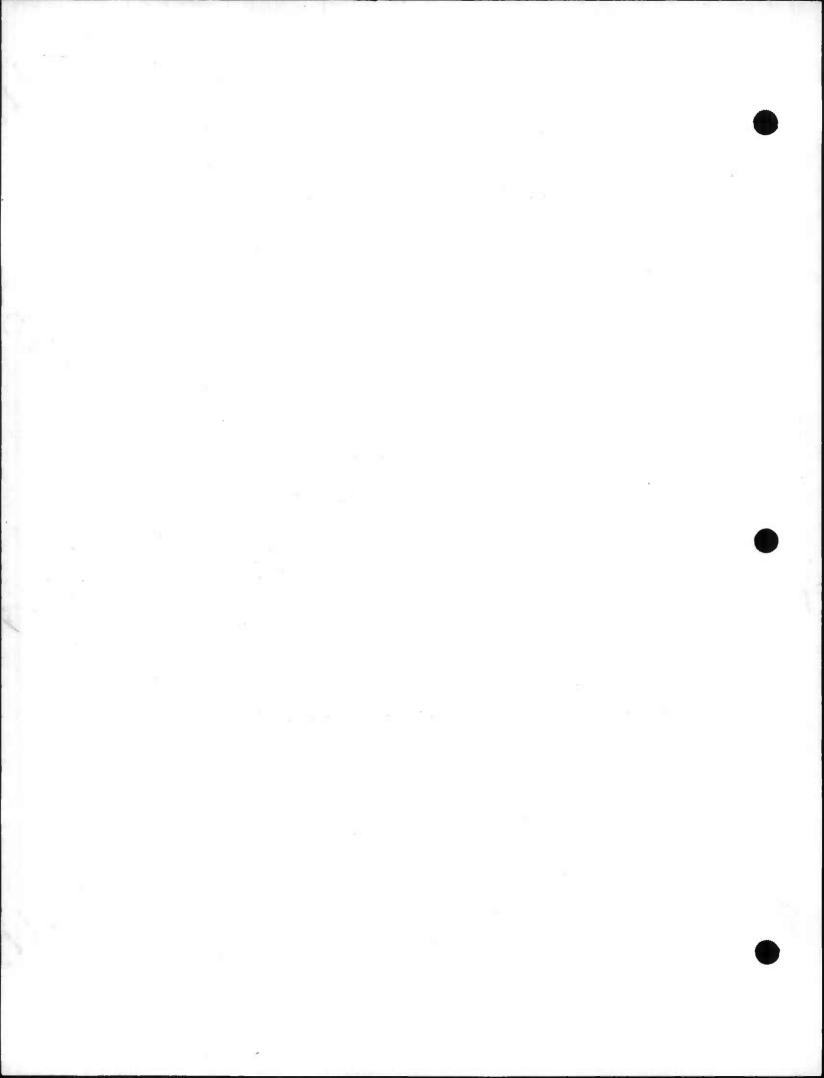
TO HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death centificate be executed within a during after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should all within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	nedistrian					JE DEALU	RE						
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR												
	CONSTANCE ANN	A KRAMER						DECEMBER 7 1994					
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. les	st birthday)	IF UNDER 1 YE		7. DATE OF BIF (Month, Day,	राम Mark	8. BIRTI	HPLACE (State or Foreign			
	142-28-1429	1 □ M 2 📝 F	70	YRS.	MONTHS DA	YS HOURS MIN.	3/23/			nnsvlvania			
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TO	WN OR LOCATION OF			COUNTY OF				
OR	GREATER BALTIMOR	E MEDICAI	. I		TOWSON		_	BALTI	MODE				
DIRECTOR	RESIDENCE OF DECEDENT								DALLI	HOKE			
2	10e. STATE 10b. COUNTY			10c. CIT	r, TOWN OR L					10d. INSIDE CITY LIMITS?			
		altimore			Towson	1				1 TYES 2 XNO			
₹ Z	10e. STREET AND NUMBER					101, ZIP CODE		10	g. CITIZEN OF	WHAT COUNTRY?			
剪	1717 Weston Aver	nue				21234			USA				
FUNERAL	11. MARITAL STATUS	12, WAS DECEDEN FORCES? 1	T EVER IN U.S. AR		13. WAS	DECENDENT OF HISP I, specify Cuban, Maxi	ANIC ORIGIN? (Spe	city Yea or N	No- 14. RAC	E — American Indian, ik, Whita, atc.			
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W				YES 2 NO Spe		etc.)	Spec	cify:			
					-				_	White			
田	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(G	live kind of v	vork done during	PATION g most of working	16b. KIND	OF BUSINES	SS/INDUSTRY				
H	Elementary/Secondary (0-12)	College (1-4 or 5 a	-)	. Do NOT us									
₹		lyear	D	isabl	Led								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						AME (First, Middle,		ame)				
BE	Jacob Albert Kra	amer					F. Kram						
2	19a. INFORMANT'S NAME (Type/Print)					eet and Number or Run			ate, Zip Code)				
	Susan Krejcik			1719	Westo	n_Avenue	Towson,	MD	21234				
	20s. METHOO OF DISPOSITION 1 5 Burisl 2 Cremetion 3 Remo	wel from State			F DISPOSITIO	N (Name of	OATE	20c. LOCATIO	ON — City or To	own, Stata			
	4 Donation 5 Other (Specify)		Locus	t_Woo	ner piace) od. Ceme	etery	12/12/94	Cam	nden, N	.J.			
	21, SIONATURE OF FUNERAL SERVICE LIC	ENSEE	11	15	22, NAM	E AND ADDRESS OF	ACILITY						
	De Charte	1 6	anna	1	Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21								
	23. PART i. Enter the diseases, or c	omplications the	Lauran Bad	1	85.	ZI Loch R	aven Blv	a. T	owson,				
	shock, or heart failure.	Liet only one ceu	se on each line	D.	ot enter the	mode of dying, ac	on se cardiac o	гтөөрпасо	ory arrest,	Approximete interval Between			
- 1	IMMEDIATE CAUSE (Final	4.1								Onset end Death			
- 1	disease or condition .	LIA . A.	+0 000							1 1			
	disease or condition recuiting in death)	Hypo	tensio	^						Joay			
	disease or condition reculting in death)	OFTO	(OR AS A CONSE	OUENCE OF	7: 0 0)[6	1 abotu				Jday			
NO	disease or condition requiting in death) Sequentially list conditions,	Infe	CION VE	OUENCE OF	CRVA	lobstr	netion			1 1			
ATION	Sequentially list conditions, if any, leeding to immediate	Infe oue to	(OR AS A CONSE	OUENCE OF	CRVA	lobstr	netion			Jday			
FICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	Infe oue to Ang	OR AS A CONSE COR AS A CONSE 10 SATC	OUENCE OF	CRVR	l obstr	uction			Jday			
TIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	Infe oue to Ang	(OR AS A CONSE	OUENCE OF	CRVR	lobstr	uction			Jday			
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	Infe oue to Ang	OR AS A CONSE COR AS A CONSE 10 SATC	OUENCE OF	CRVR	l obstr	uction			Jday			
AL CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	obeto Infe oue to Ang Due to	(OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI	OUENCE OF	C Q√R]: n the under	lying cause given I	n Pert i. 24a.	WAS AN AUTO		Jday 2 WK 21/2 yr.			
	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition	obeto Infe oue to Ang Due to	(OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI death but not i	OUENCE OF	C Q√R]: n the under	lying cause given I	n Pert i. 24s.	PERFORMED)?	2 WK 2 /2 yr. D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
EDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition	OUE TO DUE TO Contributing to	(OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI death but not i	OUENCE OF	C Q√R]: n the under		n Pert i. 24s.)?	2 WK 2 1/2 4/r. D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition than the condition of the conditio	Oue TO Ang Oue To	(OR AS A CONSE	OUENCE OF	CRVR	lying cause given i	n Pert i. 24a.	PERFORMED)?	2 WK 2 /2 yr. D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	Oue TO Ang OUE TO	(OR AS A CONSE	OUENCE OF	n the under	ying cause given l	n Pert I. 24a.	PERFORMED)?	2 WK 2 1/2 4/r. D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition Channe Tathata. DID TOBACCO USE Construction of the condition of th	OUE TO OUE TO CONTRIBUTE HOSPITAL:	(OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI death but not i	OUENCE OF	DEATH	YES N 8. PLACE OF DEATH (6	n Pert i. 24a.	YES 2)?	2 WK 2 1/2 4/r. D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition Character Significant condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	OUE TO OUE TO DUE TO CONTRIBUTE HOSPITAL: 12 Angulant 2	(OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI TO CAUSE	OUENCE OF	DEATH 2 OTHER: 4 □ Nursing	YES N 8. PLACE OF DEATH (4)	Dert i. 24a. 1	YES 2	07	2 WK 2 1/2 4/r. D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition Channe Tathata. DID TOBACCO USE Construction of the condition of th	OUE TO OUE TO CONTRIBUTE HOSPITAL:	(OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI (OR AS A CONSEI TO CAU ER/Outpettent 3	OUENCE OF OUENCE OF SE OF	DEATH OTHER: 4 Nursing E OF URY 28c	YES N 8. PLACE OF DEATH (6) Home 5 - Rasidence INJURY AT WORK?	n Pert i. 24a.	YES 2	07	2 WK 2 1/2 4/r. D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition that it is a sequence of the condition of the condi	OUE TO OUE TO	(OR AS A CONSECTION OF AS A CONS	OUENCE OF OUENCE OF Freeulting I Muse 28b. TIMI	DEATH 2 OTHER: 4 Nursing E OF URY M 1	YES N 8. PLACE OF DEATH (I Home 5 Rasidenc. INJURY AT WORK?	Dept i. 24s. 1 Dept i. 24s. 1 Dept i. 24s. 1 Dept i. 24s. 1 Dept i. 24s. 24s. 1 Dept i. 24s.	YES 2	RY OCCURED	2 WK 2 /2 yr. D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II, Other significant condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO OUE TO OUE TO DUE TO CONTRIBUTE CONTRIBUTE 1 Inpetient 2 28e. DATE OF (Month, D 28e. PLACE O building. CIAN: To the best of a: PCOMPLETEO CAUS IN THE CONTRIBUTE 32gREGISTRA 32gREGISTRA	(OR AS A CONSEINANCE OF AS	OUENCE OF OUENCE OF OUENCE OF Preculting i Muse 28b, Timin INJ Ome, farm, s sath occurre Investigatio	DEATH 2 OTHER: 4 Nursing EURY M 1 street, fectory, n, in my opinion	YES N 8. PLACE OF DEATH (6) Home 5 Residence INJURY AT WORK? YES 2 NO office dete and place, and determine the course of the cou	Dept i. 24a. 1	PERFORMED YES 2 Sify) HOW INJUF (Street and A., Street) and manner and manner	RY OCCURED Number or Rural as stated, is to the cause(d. DATE SIONE(2 WK 2 /2 yr. 2 WK 2 /2 yr. 2 WK 2 /2 yr. 2 WK 2 /2 yr. 3 WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, 8) and manner as stated.			



FOR STATE REGISTRAR

BAI TIMORE MARY! AND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

														Y YEAR 3. TIME OF GEATH			
		4. SOCIAL SECURITY NUMBER 220 20 42		5. SEX	yrs. lest birthday YRS.	MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH , Day, Year) 28,	1925	Country	PLACE (State or Form				
2, 3 should	ECTOR	9a. FACILITY NAME (If not in Harbor H	ospita				-	tim	OR LOCATION OF D		207	9c. COUN	TY OF D		<u>u</u>		
physician. burial-transit permit. Pages 1, 2,	DIREC	100. STATE Maryland	10b. COUNT	ne Arunde	1		altin		TION				10d. INSIDE CITY LIMITS? 1 YES 2 X NO				
n. ansit permi	FUNERAL	100. STREET AND NUMBER 5227 - 4t	h Stre	eet				10	1. ZIP CODE 21225			10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
ding physician.	ВУ	11. MARITAL STATUS 1 Never Married 2 3 X Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 XNO							- American Indian Whita, etc. ly: White	1,			
hospital or attending ached for use as the	COMPLETED		EDENT'S EDU y highest grade 1-12)			Ba. DECEDENT (Give kind o life. Do NOT House	f work done use retired.)		ON ost of working	16b.		usiness/ind Maker	USTRY				
by the	BE COM	17. FATHER'S NAME (First, M	I	Ernest Sp	ory				16. MOTHER'S NA		Aiddle, Maider Berk	,					
y be retained lage 5 should be notified	70	George La	ng Sr			818 I	River	side	e Drive A	pt. I) Pas	sadena	, Ma	aryland	122		
leath. Page 6 may be funeral director, page xaminer must be		1 X Burisi 2 Cremation 4 Donation 5 Other 21. SIGNATURE OF FUNERA	(Specify)		_ Center	dar Hi	other place)	Ceme	etery	CILITY	.3 Ba		re,	Maryland	i		
2 2 7		23 PAPT I From the	George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart fallure. List only one cause as each line.														
within a hour pletely filled in cremation, or cremation, or continuous the most continuous the most continuous the most continuous c		shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Interval Between Onset and Death															
ficate be execute physician and come prior to buria	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. OUE TO (OR AS A CONSEQUENCE OF):															
that the death certified by the attending th and Mental Hygies any injury, or other	빙	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													DINGS		
ires that the signed by dealth and ws any i	MEDICAL	(po	LANO	10 CAR	LUR	mp t	1 YES 2 NO							AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH?	USE		
The law te has b the Dept.	SICIAN:	DID TOBACCO		HOSPITAL:			OTHE	26. P	LACE OF DEATH (Ch	heck only on							
PHYSICIV this cert with the	BY PHYS		Pending Investigation	28a. DATE OF	INJURY	28b. T		28c. IN.	JURY AT ORK? YES 2 NO	T		INJURY OCC	URED				
OR ATTENDING DIRECTOR: After hours after death	ETED	3 Suicide 6 4 Homicide	Could not be detarmined	28a. PLACE (building.	OF INJURY — , atc. (Specify)	At homa, farm	, street, fac	lory, affic	28		ATION (Street or Town, State	and Number	or Aurel A	oute Number,			
¥ 72 =	COMPL	one) 2 MEDI	ICAL EXAMINE	R: On the beals of a					a and place, and due death occured at the) and manner sa sta	ted.		
TO THE HOSPI TO THE FUNES BE filed within	TO BE	29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	dle	Pai	SE OF DEATH	J. (ITEM 27) (74)	rter)	29c. LICENSE NUI	MBER 1614	36	29d. DATE	12/	(Month, Day, Year)			
		7850-71 31. DATE BILED (Month, Day,	year)	nericon	AR'S SIGNATI	rele,	Ge	N	Lun	2 -	AD	40	60	•			
		DEC 1 2 15	194 8	ali dend	when	Le											

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

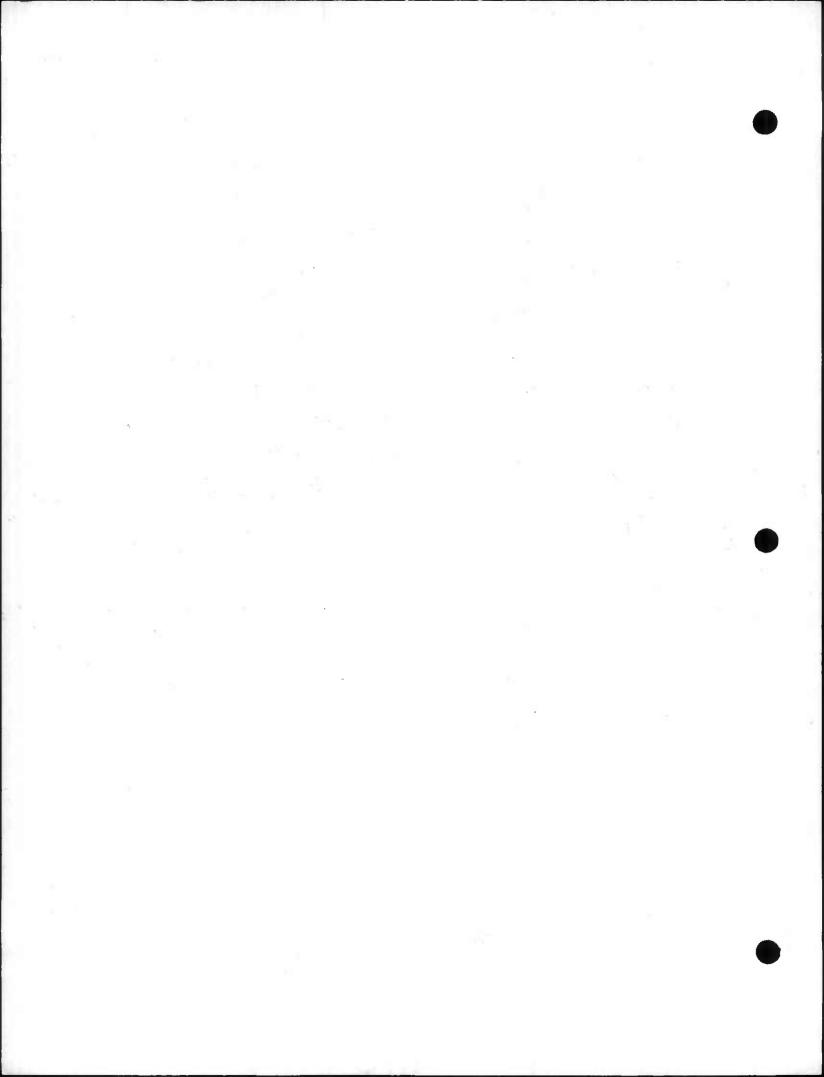
and the second of the second of the

nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICALE	JF DEA	XI H		REG. NO.			
	1. DECEDENT'S NAME (First, I								2. DATE	OF DEATH	AY	YEAR 3	. TIME OF DEATH
	ALLAN MOR								1	mber 6	19		2:50 a
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In	yrs. last birthday)	IF UNDER 1 YE		ER 24 HRS.		OF BIRTH h, Day, Year)		6. BIRTHPL Country)	ACE (State or Foreign
	217-38-1682		1 🔀 M 2 🗆 F	86	YRS.	MONTAS D	WS HOURS	MIN.	-	1, 190	в	"	land
	9a. FACILITY NAME (If not inst	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH											
O	GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE												
СТО	RESIDENCE OF DECEDENT						, printerior (p						
R	10a. STATE 10b. COUNTY					10c. CITY, TOWN OR LOCATION					10	Dd. INSIDE CITY LIMITS?	
0	Maryland Baltimore County Brook							2				1	YES 2 NO
AL	10e. STREET AND NUMBER 109. CITIZEN OF WY									AT COUNTRY?			
ÉR	2310 W. Joppa	a Road	<u> </u>			21022				U.S.A.			
FUN	11. MARITAL STATUS	200	12. WAS DECEDEN	T EVER IN U	S. ARMED	13. WAS	DECENDENT a, specify Cu	OF HISPAI	NIC ORIGI	t? (Specify Yes	or No-	14. RACE -	- American Indian.
BY 1	1 Never Married 2 Married FORCES? 1 TY YES 2 NO IF YES, GIVE WITH OR DATES				S		YES 2 N			rican, etc.)		Black, White, etc. Specify:	
0 8	21.		WWII										White
ETE		DENT'S EOUC highest grade		. 10	Give kind of	work done durir	PATION g most of wor	king	168	KIND OF BUS	SINESS/INO	USTRY	
	Elementary/Secondary (0-1	12)	College (1-4 or 5	+)	life. Do NOT u	se retired.)							
COMP			5+		Dentist				M	edical	Prof	essio	n
8	17. FATHER'S NAME (First, Middle, Lest) Edward Birckhead Lankford						16. MC	THER'S NA	ME (First,	Middle, Maiden	Surname)		
B			Lanktor	d				ısan 1					
2	19a. INFORMANT'S NAME (Typ	,								ber, City or Tow			
	Norris Birckt		ankford		2310 V	V. Jopp	oa Roa	d, B	rook	landvi	Lle,	Mary1	and 21022
	20a, METHOD OF DISPOSITION 1 TO Burial 2 Cremation	3 Rame	oval from Stata		LACE AND DATE	OF DISPOSITIO			OAT			City or Town	
	4 Donetion 5 Other (5	Specify)		Mea	ry crematory or c	Memoria	al Park	DEC.	9	Elkr	idæ. I	Maryla	nd
	21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE			22. NAI	E AND ADDE	RESS OF FA	CILITY				
	1 dots	S	lah	/-		M11	CheTT	-Wied	defe.	d Home	2	7	1 01010
	6500 York Rd. Baltimore, Maryland 21212												
	23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between												
- 1	shock, or heart failure. List only one cause on each lina.										Onset and Deat		
	disease or condition - PAEM MCORCARE PAGEMONIA & SECTIC SMOCK & PAN CTTOPENIA 3 Weeks												
- 1	DUE TO (OR AS A CONSEQUENCE OF):												
S	COPE A ARTHMATIC BRONCHITS 30 YAS									0-10-3			
ĚΙ	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								20725				
IFICATION	CAUSE (Disease or Injury C. DEMENTIA PRIFABLY ALZMEINGES 20												
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
CERTI	reaulting in death) LAST												
									ERE AUTOPSY FINDINGS				
EDICAL	ZEWAL FO	rilu re	F GT	ELEGY	120					PERFOR			MILABLE PRIOR TO OMPLETION OF CAUSE
	1 U YES 2 A NO DF DEATH?								F DEATH?				
Σ	DID TORACCO HEE CONTRIBUTE TO CAHOE OF DEATH AND												
AN	25. WAS CASE REFERRED TO		- TINIBOTE	10 0	AUGE OF				الحق	201			
Sic	EXAMINER?		HOSPITAL:	ED/O		OTHER:	6. PLACE OF						
PHYSICIAN	27. MANNER OF DEATH		1 D Inpatient 2			4 Nursing		Raaldenca			M 41 18-4	W. IMPER	
	1 Natural 5 P	ending	(Month, D		26b. Till IN.	IURY	WORK?		28d. DE	CRIBE HOW I	NJURY OCC	URED	
BY	A CONDENT	vestigation	200 81 005 0	E in titen	1.1.	'	YES 2	□ NO					
ED		ould not be	building,	atc. (Specify)	At home, lerm,	street, factory,	offica			ATION (Street a or Town, State)	and Number	or Rural Rou	te Number,
ET	20- 050515150												
COMPLET			CIAN: To the best of										
ő	2 MEDIC	AL EXAMINE	R: On the basis of a	camination e	nd/or investigation	on, in my opini	on, death occ	ured at the	time, date	and placa, an	d dua to the	e ceuse(a) a	nd manner ea stated.
3	29b. SIGNATURE AND TITLE	FERTIFIER	3 1			· · · · ·	29¢. LI	CENSE NUI	MBER		29d. DATE	SIGNED (M	fonth, Day, Year)
2	Ch	de l	Jun-	-	- my			1235	2.				- 6, ACA
¥	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETEO CAUS	SE OF OEATI	1 (ITEM 27) (Type	. Print)		_					
	CHARLES O	JO NOV	AN TI,	~	65	5 N.	Caser	2 2	-	BALT	imake,	Cm	21264
	31. DATE FILED (Month, Day, YE DEC1 2 19	884	32. TEGISTON	R'S SICNATI									
	DECT 2 19	194 /	the dience	DC NAM	ary								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. On THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfeemit. Pages 1.2.3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

					CALE	<u> </u>	DLAI	-	HEG. NO.		
,	1. DECEDENT'S NAME (First, Middle, I								2. DATE OF DEATH MONTH DA		YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	LARRY L	6. AGE (in yrs. les	a blat d- 3				10.101	DECEMBER	10,	
	1,1,0,0	1 3-M 2 - F	3 9	YRS.	IF UNDER 1 Y	EAR	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPLACE (State or Foreign Country)
	578-72-5461 9s. FACILITY NAME (If not institution,	Tho.	at CITY TO	Mar. 4, 1955 Washiin							
OR	PrinceGeorge		Oh. City, Town or Location of Death Cheverly			TH	PRINCE GEORGE				
5	RESIDENCE OF DECEDEN	unty Ince Geor		1							
DIRECTOR		"Dar	TY TOWN OR LOCATION Heights				S	10d. INSIDE CITY LIMITS? YES 2 \(\subseteq \text{NO} \)			
FUNERAL	1860 So. Ad	dison Ro	ad		101. ZIP CODE 20747				U.S.AA		
3	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. WA	S DECE	NDENT O	F HISPANIC	C ORIGIN? (Specify Yes		
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced		YES 2 THE	10	ILyı 1 □	es, spe	olly Gubar 2 1 NO	Specify:	Puerto Rican, etc.)		14. RACE — American Indian, Black, White, atc. SpecifyBlack
	15. DECEDENT'S		18a. DE	CEDENT'S L	JSUAL OCCI	JPATIO	N		16b. KIND OF BUS	INESS/INI	DUSTRY
<u> </u>	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5	. iida	ive kind of w Do NOT use	ork done duri retired.)	ing mos	t of working	g			
COMPLETED	12			Labor	5				Constr	uct	ion
ó	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	IER'S NAM	E (First, Middle, Maiden :	Surname)	
BE C	Leo Law							elen		•	aw
6	190. INFORMANT'S NAME (Type/Print) Helen Pelhan	. T 21-7							oute Number, City or Town		
	20a. METHOD OF DISPOSITION		20b. PLACE	_				n Ra		_	eights Md.
	Buriel 2 Cremation 3 Donation 5 Other (Specify)	Ramoval Irom Stata	ce/Tetaly14	olon"	Mem.	. Pa	rk		12-17-14 Sui	tla	nd, Md
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE						S OF FACI			
	* Kupur B	Balan			An	1:1	nni	run Vo	end Ser.		
	23. PART I. Entar the diseasee,	or complications the	t caused the da	ath. Do no	ot antar th	a mod	le Di dyli	ng, such	as cerdiac or respir	ratory ar	
	IMMEDIATE CAUSE (Finel	ure. Liat only one ceu	use on each line								Interval Between Onset and Death
										10days	
	11.00110.30.000000	DUE TO	(OR AS A CONSEC	DUENCE OF)	:			1	4		100075
NO N	disease or condition resulting in death) a. PRUMOCYCHS (QVINI) PREUMONIQ DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):									e	
CERTIFICATION	cause. Enter UNDERLYING										
Ĕ	CAUSE (Disease or Injury that Initiated evente Due to (or as a consequence of):										
	resulting in death) LAST	d									
0	PART II. Other significent cond	itione contributing to	death but not o	eeulting in	the unde	rlulna	001100 0	han la D	ert I. 24a, WAS AN		
EDICAL		- volume and to	deall but libt i	eouting in	i the unue	riyirig	cause y	wen in P	PERFORI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
							1 YES 2	OF DEATH?			
Σ	DID TOPACCO HISE CO	AITDIDLITE TO CA	UCE OF DEA	711 \/E) Her	11110		-		1 TYES 2 NO
A	DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICA				Check only	. 1	UNC	ERTAIN	Ш		
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER:						
Ħ	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIME	OF 28	c. INJU			Other (Specify) 28d. DESCRIBE HOW IN	JURY OC	CURED
ВУР	1 Natural 5 Pending 2 Accident Investigat	(Month, D	lay, Year)	INJU		WOR	K? ES 2 [
	3 Suicida 8 Could not	building.	F INJURY — At horate. (Specify)	me, larm, at	reet, factory,	offica		2	281. LOCATION (Street a: City or Town, State)	nd Number	r or Rural Route Number,
	4 Nomicide datarmined City of Nown, State)										
COMPLETED	29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.										
BE C	29b. SIGNATURE AND TITLE OF CERT	IFIER (Local)	no	M.	.0.	T		NSE NUMB			E SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	SE OF DEATH (ITEM	4 27) (Type, F	Print)		_	955			2-10-96
	George C. H	allor, Jr.	M-0.	4850	For	be	o Blu	id e	Lankon	, m	d 70706
0	DEC1 2 1994	whi a mulion	SINTURE								1

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAI	L HYGIENI	E			
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEAT	Н
18	Pan y	ing	LEE			Dece	mber 1		PAR 94	3:15	ам
11	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.	BIRTHP	LACE (State or Fo	reign
1	215-80-9498 9a. FACILITY NAME (If not institution, give stre	71 YRS.	ONTHS DAYS	HOURS MIN.	Apri:	1. Day, Year)	923	Country)	China		
DIRECTOR	Franklin Square Ho		96. CITY, TOWN OR LOCATION OF DEATH Baltimore				Baltimore				
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		Mc CITY	TOWN OR LOCAT	TON					10d. INSIDE CITY	
E		imore	1000 011 1,							LIMITS?	
	Md. Balt 100. STREET AND NUMBER	.more			imore	_		10a CITIZEN	_	AT COUNTRY?	NO
FUNERAL	14 6:1							A151			
2	14 Silverwood Ct.	12. WAS DECEDENT EVER IN	N U.S. ARMED		21236 ENGENT OF HISPA	NIC ORIGIN	7 (Specify Vec		ina	— American India	
	1 Never Married 2 Married	FORCES? 1 YES	2 300	If yes, sp	ecify Cuban, Maxica 2 X NO Specifi	en, Puerto F	Rican, etc.)	14.	Black,	White, atc.	ит,
BY	3 Widowed 4 Divorced	120, 0.12 1811 011 01		I I TES	ZA NO Specii	у.			Specify	Chines	e
COMPLETED	15. DECEDENT'S EOUC/ (Specify only highest grade of	ATION	18a. DECEDENT'S US	SUAL OCCUPATION The done during mo	ON of a warting	16b.	KINO OF BUS	INESS/INOUS	FRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	at of working						
	12		Home M	aker	_		Own H	ome			
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, A	Aiddle, Maiden S	Surname)			
BE (Chu Cho	W	Chuw		Chu	Koo		May-s	han		
6	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DORESS (Street a	nd Number or Rural	Route Numb	er, City or Town	, State, Zip Co	de)		
	Mr. Hung Cheng Lee	4	14 Sil	verwood	Ct. Bal	timo	re, Md	. 2123	6		
- 1	20a. METHOD OF DISPOSITION 1 □XBurial 2 □ Cremation 3 □ Ramov		.PLACE AND DATE OF etery, cremetory or other		me of	DATE	20c. LOC	ATION — CITY	or Tow	n, Sfeta	
	4 Donation 5 Other (Specify)	Du.	laney Val	ley Mem			/94 Ti	monium	, M	id.	
	21. SIGNATURE OF FUNERAL SERVICE LICE	WHEEL ()			D ADDRESS OF FA		- 1 II	. T			
	Harry	778 (X			Towson F York Rd.						
	23. PART i. Enter the diseases, or co	emplications that caused	tha death. Do not							Approxime	eta
1	ahock, or hasrt fallure. Li IMMEDIATE CAUSE (Final	iat only one ceuse on e	sch iina.							interval Ba	
	disease or condition resulting in death)										
	a.	DUE TO (OR AS A	CONSEQUENCE OF):							1	
z	Sequentially list conditions, b.	Interstiti									
ĔI	if any, leading to immediate		CONSEQUENCE OF):	sis							
2	CAUSE (Disease or Injury c.	Bronchiect									
Ë	that initiated avents resulting in death) LAST	DUE TO (OH AS A	CONSEQUENCE OF):								
CERTIFICATION	d.										
AL (PART ii. Other eignificant conditions	contributing to deeth b	ut not raculting in	the undarlying	cause given in	Part i.	24s. WAS AN /			VERE AUTOPSY FIL	
				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			PERFORMED? 1 □ YES 2次□ NO			WAILABLE PRIOR 1 COMPLETION DF G	
MEDIC						_				OF DEATH?	10
-	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	□ NO K	UNCERTAIL	N \square					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH								
Sign		HOSPITAL: 1 X Inpetient 2 ☐ ER/Outp		OTHER:	e 5 🗆 Rasidence	8 🗆 Other	(Specify)				
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (URY AT	28d. OE\$	CRIBE HOW IN	JURY OCCUR	ED		
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 1							1
	3 Suicide 8 Could not be	- At home, farm, stre	et, factory, office	1	28f. LOCA City o	ATION (Street ar	nd Number or F	Rural Ro	ute Number,		
	4 Homicide determined										
7		AN: To the best of my knowl	edge, death occurred	at the fime, data	and place, and dua	to the cau	se(s) and man	ner as stated.			
Secretary of the determined and place and due to the cause(s) and manner as stated. City or Town, State and place, and due to the cause(s) and manner as stated. City or Town, State and place, and due to the cause(s) and manner as stated.								and manner as st	sted.		
	296. SIGNATURE AND TITLE OF CERTIFIER	,			29c. LICENSE NUI	MHER		29d. DATE SI	GNED//	Month. Day. (har)	
BE	Elist W3	at m	つ					▶ /2	2/10	194	1
임	30. NAME AND ADORESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pr	rint)					1		-
	Eliot Battle M.D	., 9000 Fran	klin Squa	are Dri	ve Balti	more.	MD 21	237			
	31. DATE FILED (Month, Day, Year)	22. REGISTRANDSIGNA	ATURE		-				-		
l	DEC1 2 1994 Julia	Chimeracacara	146								

. . .

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the state death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

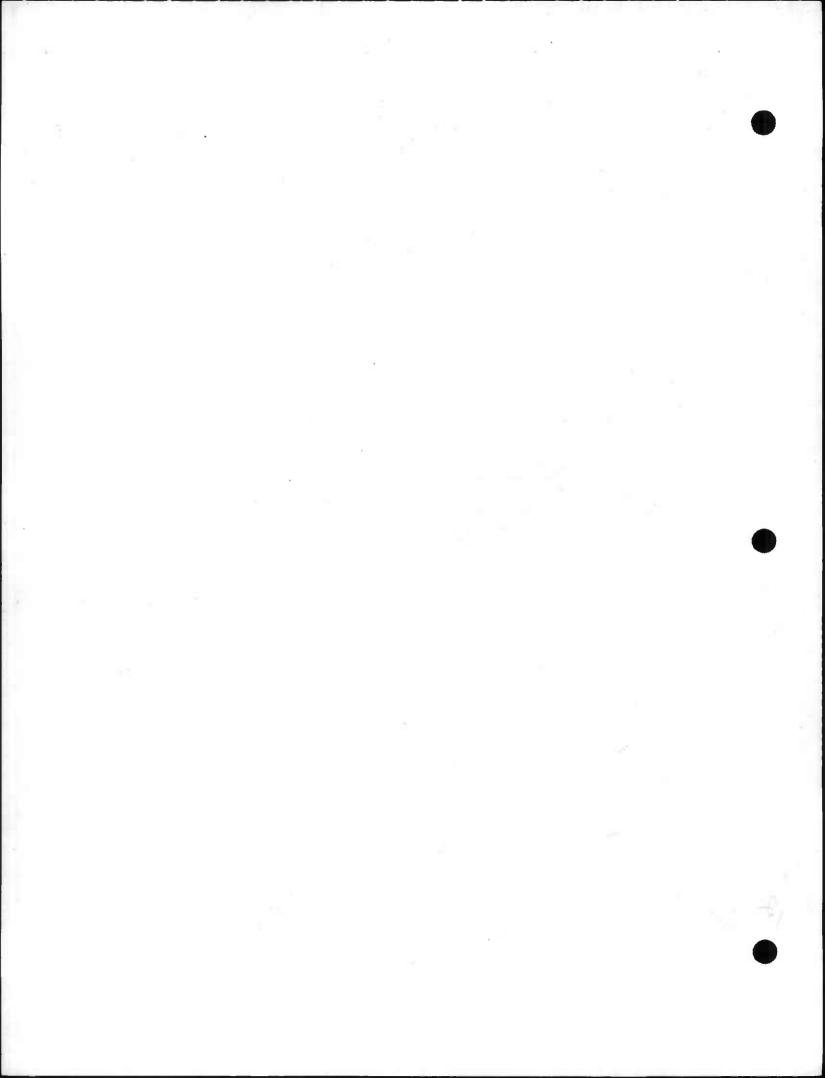
If I have within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MENTALL II item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			IFICATE (JI OLAIII	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA	ıv.	YEAR	3. TIME OF DEATH
		Marg	uerite	Love		Dec. 8			12:45PM
li	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. last birthe	(ay) IF UNDER t Y		7. DATE OF BIRTH		8. BIRTHE	PLACE (State or Foreign
	212-74-8898	1 🗆 M 2 😾 F	96 YR	S. MONTHS D.	NYS HOURS MIN.	April 26, 18	398	Mary	yland .
	9a. FACILITY NAME (If not institution, give	street and number)	9b. CITY, TO	9b. CITY, TOWN OR LOCATION OF GEATH			9c. COUNTY OF DEATH		
S S	Cardinal Shehan (Center	Tows	Towson			Baltimore County		
5	RESIDENCE OF DECEDENT								ee oddiey
DIRECTOR	10a. STATE 10b. CDUN		CITY, TOWN OR L	OCATION		tod. INSIDE CITY LIMITS?			
		Lmore Coun	ty T	owson					1 - YES 2 NO
14	10e. STREET AND NUMBER			10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	2300 Dulaney Val				21204				U.S.A.
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT I	YES 2 THO	13. WAS	DECENDENT OF HISPA s, specify Cuban, Mexico	NIC ORIGIN? (Specify Yea	or No-	14. RACE Black.	— American Indian, White, etc.
ВҰ	3 Widowed 4 Divorced	IF YES, GIVE WAR	YES 2 ND		YES 2 ND Specif		Ì	Specify	y:
ED	15. DECEDENT'S ED	ICATION	46- 050505						White
	(Specify only highest gred	e completed)	(Give kind	IT'S USUAL OCCU of work done during of use retired.)	PATION og most of working	16b. KIND OF BUS	SINESS/INC	DUSTRY	
12	Elementery/Secondary (0-12)	College (1-4 or 5+)				~	homo		
COMPLET	17. FATHER'S NAME (First, Middle, Last)			naker		ME (First, Middle, Maiden	home		
	John R. Miller					ret Hiltz	Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)		105 4441	INC ADDRESS (C		Route Number, City or Tow	0		
일	Richard A. Love					arks-Glenco			and 21152
			20b. PLACE AND DA			DATE 20c. LO			
	20a_METHOD OF OISPOSITION 1 A Burlat 2 Cremation 3 Rer 4 Donation 3 Other (Specify)	noval from State	cometery, crematory New Cat	or other place)		nber12 Balt			
	21. SIGNATURE OF FUNERAL SERVICE	CENSEE	J New Cat.	22. NAI	DECEI	IDELIZ DATI	TUIOT	e, m	aryranu
	1897	201		Mi	tchell-Wie	edefeld Hon	ne		
	10 mes	2		65	00 York Ro	d. Baltimor	e, M	aryla	and 21212
	23. BART . Entar tha diseases, or shock, or heart failure.	List only one stust	caused the death. I	Oo not antar the	moda of dying, suc	ch as cardiac or reapi	ratory arr	reat,	Approximata
	IMMEDIATE CAUSE (Final			hele	m5				Intarval Between Onset and Death
	disease or condition resulting in death)	0.	" ()	/					
resulting in death) a. OUE TO (DR AS A CONSEDUENCE OF):									
	IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (DR AS A CONSEDUENCE OF): A GARGE A GARGE IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (DR AS A CONSEDUENCE OF): A GARGE A G								
N N	Sequentially list conditions	Di .			5 1/15:	108			
ATION	Sequantially list conditions, if any, leading to immediate	Di .	OR AS A CONSEDUENCE		5 1/18:	108		_	
-ICATION	If any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury	DUE TO (D	PR AS A CONSEDUENC	E DF):	19/15	102			
TIFICATION	If any, leading to immediata cause. Entar UNDERLYING	DUE TO (D		E DF):	es left si				
CERTIFICATION	if any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants	DUE TO (D	PR AS A CONSEDUENC	E DF):	es Wisi	,			
AL CERTIFICATION	if any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants	OUE TO (D d.	OR AS A CONSEQUENCE	E OF):		Parti 24a WASAN			WERE AUTOPSY FINDINGS
	If any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST	OUE TO (D d.	OR AS A CONSEQUENCE	E OF):		Part I. 24a, WAS AN	MED7	0.77650	AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	If any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST	OUE TO (D d.	OR AS A CONSEQUENCE	E OF):		Parti 24a WASAN	MED7		AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY
MEDICAL	If any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST	OUE TO (D d.	OR AS A CONSEQUENCE	E OF):		Part I. 24a, WAS AN	MED7		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST PART II. Other significant conditions of the conditions of the cause of the conditions of the cause	OUE TO (D d.	OR AS A CONSEQUENCE	E OF): E OF):	iying cauaa givan in	Part I. 24a, WAS AN PERFOR	MED7		AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST PART II. Other significant conditions the significant conditions of the significant condit	DUE TO (D c. DUE TO (D d. ns contributing to de	OR AS A CONSEDUENCE	E OF): E OF): ng in the under	lying cauaa givan in	Part I. 24a, WAS AN PERFOR	MED7		AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other signific	DUE TO (D c. DUE TO (D d	R AS A CONSEDUENCE	E OF): E OF): OTHER: A Durning TIME OF 28	iying causa givan in 6. PLACE OF DEATH (Ch Plants 5 C Residence	Part I. 24e, WAS AN PERFOR 1 1 YES 2	MED7		AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY
PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d. ns contributing to de	R AS A CONSEDUENCE	E OF): E OF): E OF): Time of 28: Time of 28:	iying causa givan in 6. PLACE OF DEATH (Ch Honte 5 Residence . INJURY AT	Part I. 24a, WAS AN PERFOR	MED7		AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d	RAS A CONSEDUENCE OF AS A	E OF): E OF): Time of the under th	iying causa givan in 6. PLACE OF DEATH (Ch Plants 5	Part I. 24a, WAS AN PERFOR 1 YES 2 MICK ONLY OTH) 8 Other (Specify) 28d, DESCRIBE HOW II	MEDY NO	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY!
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d	RAS A CONSEDUENCE OF AS A	E OF): E OF): Time of the under th	iying causa givan in 6. PLACE OF DEATH (Ch Plants 5	Part I. 24e, WAS AN PERFOR 1 1 YES 2	MEDY NO	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY!
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d	RAS A CONSEDUENCE OF AS A	E OF): E OF): The of a street factory.	lying cause given in 6. PLACE OF DEATH (C) Home \$ Residence . NuJury AT WORK? VES 2 NO	Part I. 24a, WAS AN PERFOR 1 TYES 2 BICK ONLY OTHER BIT OTHER (Specify) Zed, DESCRIBE HOW II Zee, LOCATION (Stoner of Chy or Rown, State)	MEDT NO	CURED or Plumi Pc	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY!
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d	R AS A CONSEDUENCE OR AS A CONSEDUENCE CONSEDUENCE OR AS A CONSEDU	E OF): E OF): The of the under the time.	E. PLACE OF DEATH (Ch. Hama 5 Residence HAJDHY AT WORKT YES 2 NO office	Part I. 24a, WAS AN PERFOR 1 TYES 2 MCK ONLY OTHER B TO Other (Riphorly) Zel. LOCATION (Stout a City or Town, State)	MEDT NO	CURED or Floral Fic.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY! 1 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d	R AS A CONSEDUENCE OR AS A CONSEDUENCE CONSEDUENCE OR AS A CONSEDU	E OF): E OF): The of the under the time.	iying cause given in 6. PLACE OF DEATH (Ch. Plants 5 Residence INJURY AT WORKY VES 2 NO office thate and place, and sha	Part I. 24a, WAS AN PERFORM 1 YES 2 Mack only one; 8 Other (Renofy) 28t. LOCATION (Street a City or Rent, State) 10 the ceums(s) and men time, date and place, an	MEDT NO NAURY OCCURRY	or flural fits ed. scause(s)	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY! 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	DUE TO (D c. DUE TO (D d	R AS A CONSEDUENCE OR AS A CONSEDUENCE CONSEDUENCE OR AS A CONSEDU	E OF): E OF): The of the under the time.	E. PLACE OF DEATH (Ch. Hama 5 Residence HAJDHY AT WORKT YES 2 NO office	Part I. 24a, WAS AN PERFORM 1 YES 2 Mack only one; 8 Other (Renofy) 28t. LOCATION (Street a City or Rent, State) 10 the ceums(s) and men time, date and place, an	MEDT NO NAURY OCCURRY	or flural fits ed. scause(s)	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY! 1 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART III. Other significant condition PART II. Other sign	OUE TO (D c. DUE TO (D d	PR AS A CONSEDUENCE OR AS A CONSEDUENCE CONSEDUENCE OR AS A CONSEDUENCE CONSED	E OF): E OF): Take OF Manual at The time. pation, in my opini	S. PLACE OF DEATH (Ch. Plants S Residence INJURY AT WORKY VES 2 NO office thate and place, and sha	Part I. 24a, WAS AN PERFOR 1 TYES 2 MCK ONLY OTHER TOWN IS CAY OF TOWN, State) 281. LOCATION (Stone) and then time, date and place, an MICR 4	MEDT NO NO NOTICE THE TOTAL NOTICE THE T	or flurel fic	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO sule Number and manner as stated. (Month, Day, Yapr)
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1	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physic	s after death. Page 6 may be retained by the hospital or attending physic
TO THE FUNERAL	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial	by the funeral director, page 5 should be detached for use as the burial
De nied within /2	De migd within /2 hours after death with the State Lept. Of neadurally western hybrine pain to out all centurods.	emoral.
IMPURIANT: II	IMPORIANT: IT HEM 28 IS MATRED, OF HEM 23 SHOWS ANY HIGHY, OF CHECK LAUMANC EVENT, THE MEDICAL EXAMINET MUST DE NOTHEGO AT ONCE.	dical examiner must be notined at once.

Item#18 Per F.H Film# G-718 12/12/94 R.M. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Edward Mahan 1994 Dec. 1:15 A. 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTNPLACE (State or Foreign 013-03-2212 76 1 🔯 M 2 🗌 F July 12,1918 Mass. Sa. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF OFATH 9c. COUNTY OF DEATH DIRECTOR 4 Stayman Drive Apt. D Catonsville Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10a, STATE 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4 Stayman Drive Apt. D 21228 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married if yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 NO Specify: Specify: 3 Wildowed 4 Divorced BY White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Accountant 12 State Of Maryland 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname Maude Burliggame Edward Mahan BE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. INFORMANT'S NAME (Type/Print) Number, City or Town, State, Zip Code) 21228 Catonsville Maryland 2 John Decker 4 Stayman Drive Apt. G 20a. METHOD OF DISPOSITION

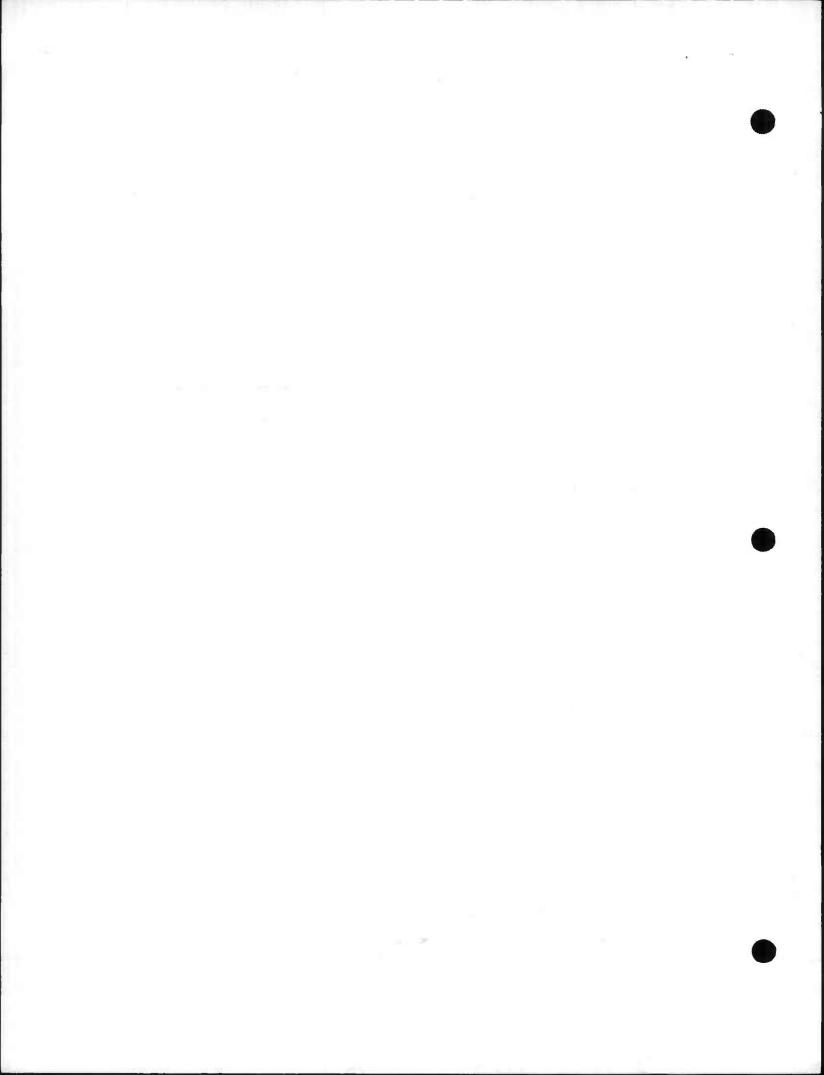
1 St Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 12-10-94

22. NAME AND ADDRESS OF FACILITY Marriottsville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, shock, or heert fellure. List only one cause on each line. interval Between **Onset and Death** IMMEDIATE CAUSE (Fine) disease or condition RAPSMONAL ETASTATIC resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 T NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA **EXAMINER?** OTHER: 1 TYES TO NO 4 Nursing Home 5 Realdenca 8 Other (Specify) 27. MANNER OF DEATN 28s. DATE OF INJUST 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 28b. TIME OF Natural 2 Acciden 1 YES 2 NO ВУ Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Sulcide Could not be COMPLETED Homicide CENTIFIER CENTIFYING PHYSICIAN viedge, desth occurred at the time, date end pieca, and dua to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: restigstion, in my opinion, death occured at the time, data and piece, and due to the cause(a) and mennar as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Meer)

1 3 7 9 4 BIGNATURE AND VITLE OF CHATIFUE BE

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3. TIME OF DEATH

B. BIRTHPLACE (State or Foreign

Pennsylvania

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

U.S.A.

Specify:

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, crematic	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, th
		-	2	_

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Anna 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) 10/22/02 1 M 2 DEF 92 150-38-6076 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH St. Agnes Hospital Baltimore 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Baltimore Arbutus 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 907 Circle Drive 21227 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 - YES 2 1 NO Specify: 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spec Elementery/Secondary (0-12) College (1-4 or 5+) 8 none none 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alfred Carrara Louisa Batista 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) John DeRosa 5001 Westland Blvd., Apt H, Arbutus, MD 21227 20a METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 Donetion 5 Other (Specify) 01ivet Cemetery 12/13 Elizabeth, NJ 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 328 Sulphur Spr.Rd., Arbuu 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, ahock, or haart fallura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Sepsis resulting in death) DUE TO (OR AS A CONSEQUENCE OF): bring Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant gonditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN

26. PLACE OF DEATH (Check only one)

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t TYES 2 NO

Interval Between

Onset and Daath

25.	WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	
27.	MANNER OF DEATH	

1 Natural
2 Accident 5 Pending Investigation 3 Sulcide

HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA 28s. DATE OF INJURY (Month, Day, Year)

4 Nursing Home 5 Residence 8 Other (Specify) 26b. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)

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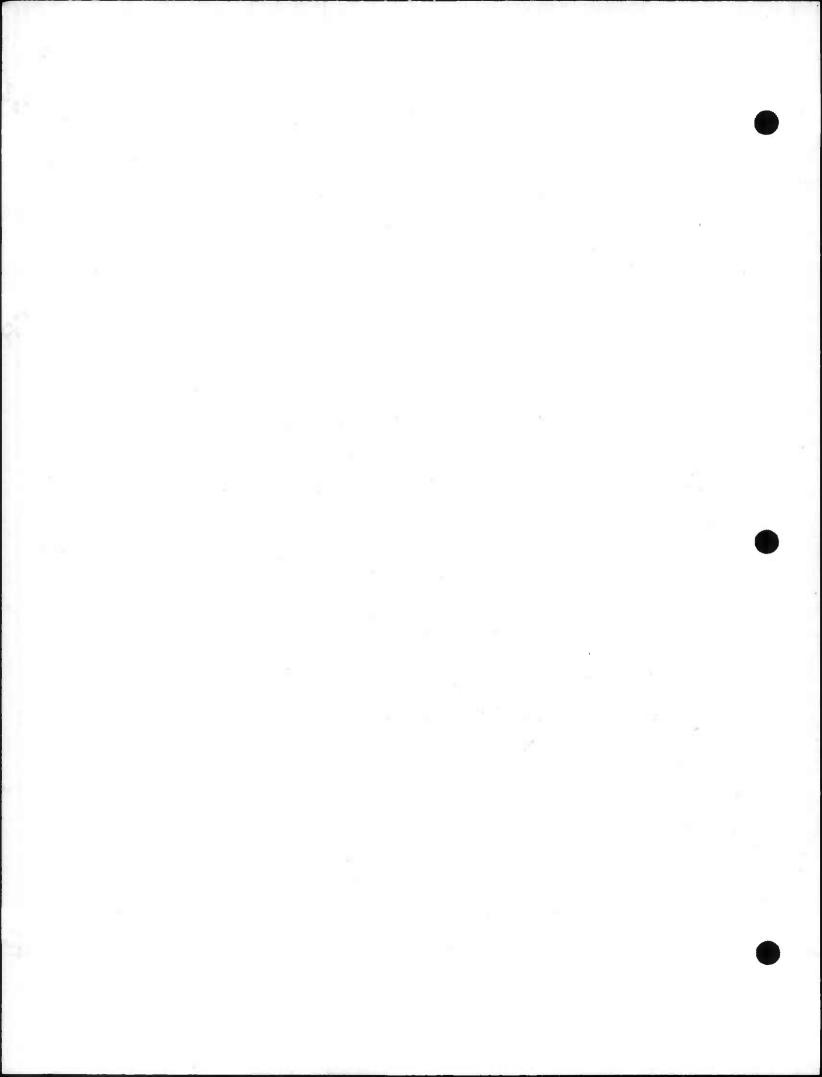
29e, CERTIFIER best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.

28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)

2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CENTRIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month

_	_	-/-		_						
D. NAME	pMp	ADDRESS OF	PERSON	WHO	COMPLETED	CAUSE	OF DEAT	H (ITEM	27) (Type	e, Pri

31. DATE FILED (Month) Day, Year)



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CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 12 8 Francis May AM Francis Nicholas May 4. SOCIAL SECURITY NUMBER 5 SEX 7. DATE OF BIRTH (Month, Day, Yea 6. AGE (In yrs. last birthday) 8. BIRTNPLACE (State or Foreig IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1- M 2 - F 217-20-9615 YRS 67 May 4, 1927 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Johns Hopkins Bayview Medical Center Baltimore City N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland N/A Baltimore City 1 YES 2 | NO permit. 10e. STREET AND NUMBER 10f. ZIP CODE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 625 Umbra Street 21224 U.S.A. the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11, MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black, White, atc. **MARYLAND** 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR OATES 1 YES 2 XNO Specify: B∀ 3 Widowed 4 Divorced White WWII use as 6 15. DECEDENT'S EDUCATION 18a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INOUSTRY (Specify only high P Elementary/Secondary (0-12) Coffege (1-4 or 5+) COMPL 12th Grade page 5 should be detached Police Detective Baltimore City 17, FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Ħ Nicholas NMN May Margaret Unknown Foos notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Martha Anna May 625 Umbra Street, Baltimore, Maryland 21224 8 pe 20a. METHOD OF OISPOSITION
1X Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 12/12/94) Gardens of Faith Cemetery 2 must Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between 9 **Onset and Death** IMMEDIATE CAUSE (Final cremation, the Pul way emb disease or condition resulting in death) embolus one hour event, to burial, 2 days Intra-operative Stacic traumatic CERTIFICATION Sequentially ilst conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate prior cause. Enter UNDERLYING CAUSE (Disease or injury or other OUE TO (OR AS A CONSEQUENCE OF): Mental Hygiene that initiated events resulting in death) LAST shows any injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL of Health and COMPLETION OF CAUSE 1 MYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) item the State **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Nonpetlant 2 ER/Outpetlant 3 DOA ng Home 5 🗆 Residence 8 🗆 Other (Specify) ò 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 28 is marked, death with INJURY 1 Natural 5 Pending 1 YES 2 NO 8 2 Accident Investigation 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sufcide after c 8 Could not be COMPLETED 4 Homicide if item hours 29a CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE Resident Surgeon Dwans D41129 12-8-94 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St. Baltimore 21287 PETER Johns Hoplans Hosp. ctto 31. DATE FILEO (Month, Day, Year) 32. PEGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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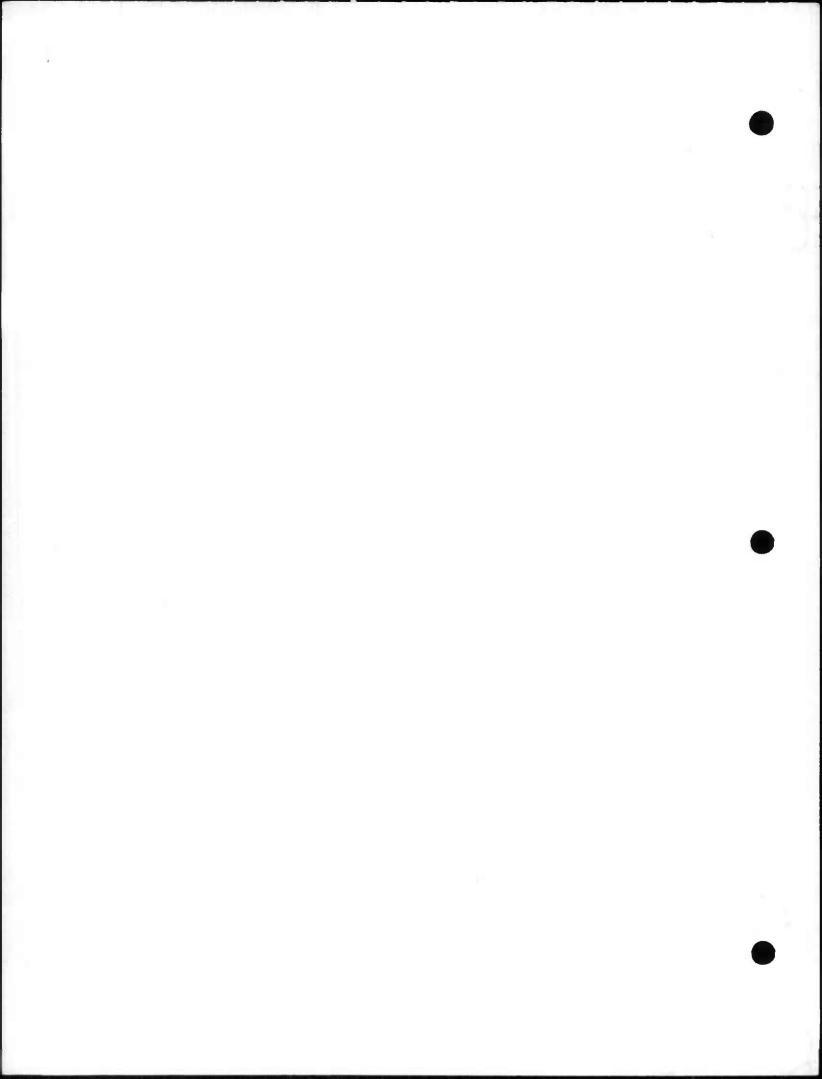
DIVISION OF VITAL RECORDS, P.O. BOX 6

hospital or attending physician.	entificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		
YSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be de	removal.	1, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
certificate be executed with	iding physician and completely filled in	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ir other traumatic event, the me
ICIAN: The law requires that the death	certificate has been signed by the atte	the State Dept. of Health and Mental	, or item 23 shows any injury, o
THE HOSPITAL OR ATTENDING PHYS	IN THE FUNERAL DIRECTOR: After this	within 72 hours after death with	MPORTANT: If item 28 is marked

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	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND /				EALTH DEAT		MENTAI	HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Li	ast)							2. DATE		1	- 225	3. TIME OF OEATH
	Joan	F.	Me	rril	1				Dec	of OEATH	11	994	9:30 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. lest	it birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7 DATE	OE BIOTH		6. BIRTN	IPLACE (State or Foreign
	116-22-2803	1 🗆 M 2 🔀 F	65	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	10,19	229	Country	y)
	9e. FACILITY NAME (If not institution, g	nive atreet end number)			ah CIT	Z TOWN C	OR LOCATIO			10,1.		NEW NTY OF DI	y York
DIRECTOR	5492 Marsh Haw	vk Way					mbia		AIR		9C. COU		vard
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2				10c. CITY, TOWN OR LOCATION Columbia								10d. INSIDE CITY LIMITS?	
	Maryland	Howard											1 TYES 2 X NO
FUNERAL	10e. STREET AND NUMBER	1 **				101.							VHAT COUNTRY?
I I	5492 Marsh Haw	-					21	045				U.S	S.A.
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									1				White
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5	19e. INFORMANT'S NAME (Type/Print)									er, City or Yowi		100	
-	Nancy Paulis	(Daughter) 5	5492	Mars	sh Ha	awk W	ay C	colum	bia Ma	iryla	nd	21045
	20e. METHOD OF DISPOSITION 11√2 Burlel 2 ☐ Cremetion 3 ☐ F	Dommer State	20b. PLACEA	ANDDATE	OF DISPOS	SITION (Nat	me of		DATE	20c. LO	CATION —	Cify or To	wn, State
	4 Donetion 5 Other (Specify)		St. BC	matory or or or or or or or or	ther place)	emet	ery	12/1	3/94	Elmo	ont,	New	York
	21. SIGNATURE OF FUNERAL SERVICE	I PICENSEE	/		22.	NAME AN	ID ADDRES	S OF FAC	YTIJIC				
	Leroy M & Russell C Witzke Funeral Homes												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such so cardiac or respiratory arrest, Approximate												
	ahock, or haert falls	, or complications the ure. List only one cau	t ceueed the deuse on each line	sth. Do n	not enter	the mod	de of dyle	ng, such	ee card	liac or raspl	ratory arr	est,	Approximate interval Between
	IMMEDIATE CAUSE (Final							Onset and Death					
	disease or condition resulting in desth)	a	ロストリ	ric	-	DV 0	احما	L	نف	n cer			2 mi
		DUE TO	(OR AS A CONSEC	DUENCE OF	F):								0
Z	Sequentially list conditions,	b											
Ĭ	If any, leading to immediate	DUE TO	(OR AS A CONSEC	JUENCE OF	F):								
2	Cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
ERTIFICATION	that initiated events	DUE TO	(OR AS A CONSEC	JUENCE OF	F):								
EH	resulting in death) LAST	d											
ū	PART II. Other algolificant condi	ittions contribution to	death but not r	- oulting	In the su	- destutor		bea la l	21			1	
MEDICAL	PAINT III Other argument of	Mona commoning to	Geath put libt	Baninia .	In the un	Ideriying) cense A	IVen in i	Part I.	24e. WAS AN PERFOR		240.	AVAILABLE PRIOR TO
ă									— I	1 YES 2	NO	1	OF DEATH?
ME													1 TES 2 NO
	DID TOBACCO US		E TO CAL	JSE O	F DEA	ATH '	YES [] NO					
CIA	25. WAS CASE REFERRED TO MEDICA EXAMINER?						ACE OF DE	EATN (Che	eck only on	e)			
PHYSICIAN:	1 TES 2 NO	HOSPITAL: 1 inpetient 2	ER/Outpatient 3	□ DOA	4 Nun		• 5 Rad	eldence	6 🗆 Other	r (Specify)			
Ĕ	27. MANNER OF DEATN	26a. DATE OF (Month, D		26b. TIM	ME OF JURY	28c, INJU	URY AT		28d. DES	CRIBE NOW II	JURY OCC	CURED	
ВУ Б	Natural 5 Pending 2 Accident Investigati		ay, rom,		M		YES 2] NO					
	3 Suicide 6 Could not	26e. PLACE O	OF INJURY — At hor	me, farm,	street, fac	tory, office		\rightarrow		ATION (Street e	nd Number	or Rural A	loute Number,
TED	4 Nomicide determine		, etc. (Specify)						City	or Town, State)			
LET	290. CERTIFIER CERTIFYING PI	PHYSICIAN: To the best of	4 bvlados, de	-th page	of at the s	data	-d alone	2.4.4					
MP		MINER: On the besie of e											
COMPL			Administration and/or i	riveatigatio	M, III HIY C	pinion, or	wath occur	JICI SIT TING 1	time, date	ena piace, en	3 due to th	e ceuse(e)) end manner ee stated.
BE	296. SIGNATURE AND TITLE OF CERT	IFIER						NSE NUM			29d, DATE	E SIGNED	(Month, Day, Year)
0	12 (C)	216					D) 4	+113	9.		▶ <i>ℓ</i>	21	9/94
1 = 1	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CALL	SE OF DEATH /ITE	4 27) /Smr	Print)								

Julia Durlian Rawall

31. DEC 1 2 1994



3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH MONTH

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FOR STATE REGISTRAR

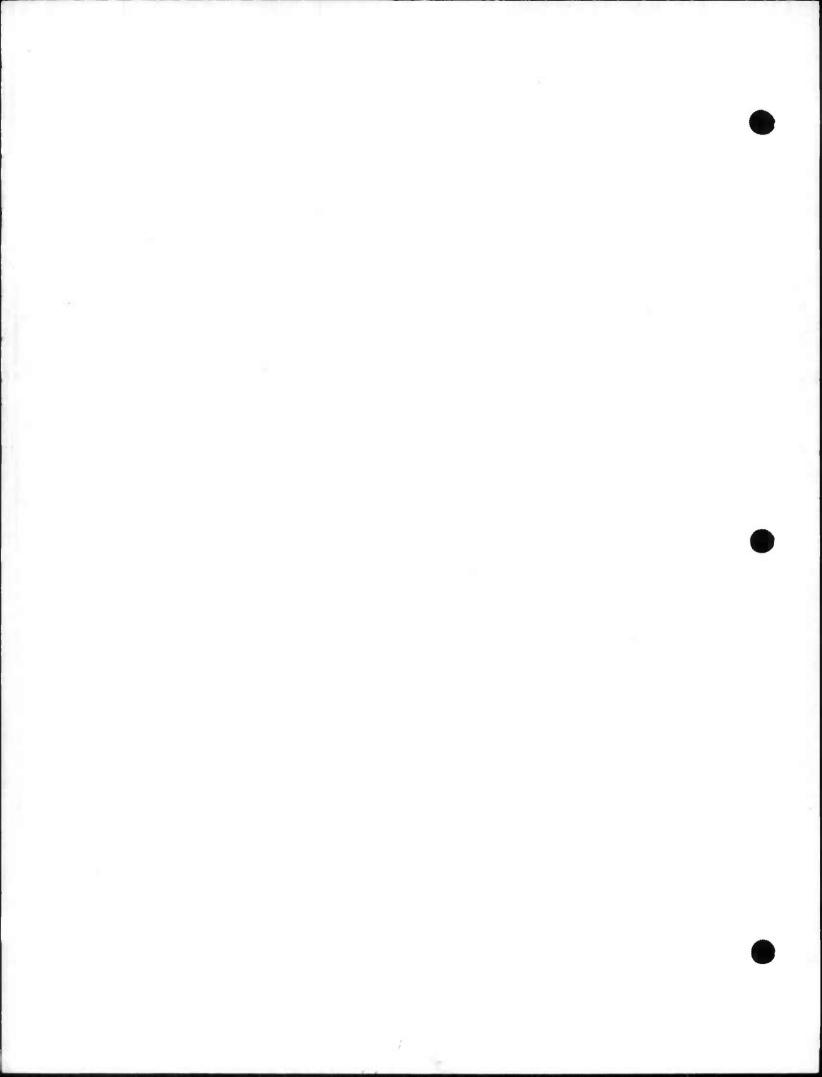
1. DECEDENT'S NAME /First Middle Last)

MARY JANE

4. SOCIAL SECURITY NUMBER DEC 10 1994 6:31 A M JANE MacKENZIE 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) DAVE HOLIDA 192-26-2945 58 1 🗆 M 2 🔯 F Sept. 17, 1936 Pa Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1301 Middleford Road Baltimore DIRECTOR Catonsville RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Catonsville 1 TES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21228 1301 Middleford Road filled in by the funeral director, page 5 should be detached for use as the burial-transit U.S.A. retained by the hospital or attending physician. 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried 1 YES 2 NO Specify: В 3 ▼ Widowed 4 □ Divorced White ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementery/Secondery (0-12) College (1-4 or 5+) COMPL 12 Homemaker Own Home 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) James J. Kinsella Ħ May H. Hiller BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1301 Middleford Road Catonsville Maryland 21228 John J. MacKenzie (Son) hours after death. Page 6 may be pe g 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Nemaporal 2-14-94 members, cremetors or other place)
Maryland Veterans Cemetery DATE 20c. LOCATION - City or Town, State must 1 Buriet 2 Cremetion 3 Rem
4 Donetion 5 Other (Specify) Garrison Forest, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes Luxuee 1630 Edmondson Avenue Catonsville Maryland removal the medical 23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Interval Between 0 IMMEDIATE CAUSE (Finel Onset and Death disesse or condition and completely fi burial, cremation Respiratory Arrest resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): 3months III sept 2 mullsym stase III traumatic CERTIFICATION attending physician and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY MEDICAL signed by t Health and Acute anemia, Multiple compression any 1 TYES 2 NO OF DEATH? Shows Thrombocytopinia 1 - YES 2 40 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES certificate has be h the State Dept. PHYSICIAN: NO X 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check Tem I **EXAMINER?** HOSPITAL: 1 YES 2 NO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 0 碧 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. WITH this 1 Netural 2 Accident 5 Pending Investigation 1 YES 2 NO BY Апег death 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 3 Suicide 28t, LOCATION (Street and Number or Rural Route Number, City or Town, State) 27 6 Could not be 28 / COMPLETED 4 Homicide Item 29e. CERTIFIER (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check ank (Check (Check ank (Check (C (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated. = TO THE HOS-TO THE FUNER be filed within 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 030573 MO 12-11-94 0 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEC1 2 1994 37 REGISTRAR'S CONTURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	P	B	Ξ	82
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	TO THE HOSPITAL ATTENDED PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIFFERENCE AND this certificate has been signed by the attending physician and completely fi	THE STATE OF	IMPORTANT IN tem 28 is marked, or item 23 shows any injury, or other traumatic event, th
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The control of a second of the control of the contr	e attending physician and completely filled in by the funeral director, page 5 shou	Mental Hygiene prior to burial, crema	arked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
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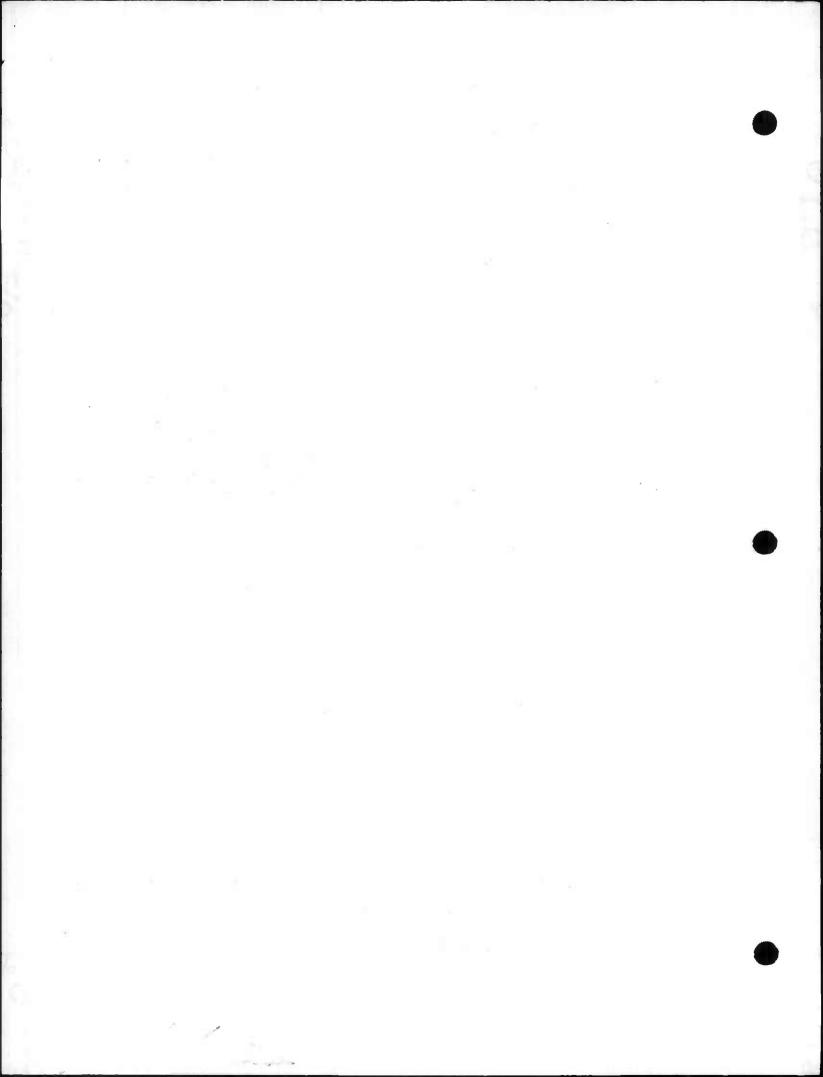
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last)

	HILDA MERRITT DECEMBER 9, 1994 8:19 AM								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1. UNDER 1 YEAR IF UNDER 124 HRS. 7. DATE OF BIRTH (Month, Day, Year) Country) 6. BIRTHPLACE (State or Foreign Country)								
	9e. FACILITY NAME (If not Institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
S S	NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A. COUNTY								
DIRECTOR	RESIDENCE OF DECEDENT 10. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?								
	$N = \frac{N \cdot Q}{N \cdot Q} = N \cdot N \cdot N \cdot N \cdot N \cdot N \cdot N \cdot N \cdot N \cdot N \cdot$								
FUNERAL	9901 MIDELE MILL DrIVE 31117 U.S.A								
	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Merried 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 11 yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, 15. Black, While, etc. 15. Sectiv: 17. YES 2 WAS DECEDENT OF HISPANIC ORIGIN? (Specify: 18. Type, specify Cuben, Mexicen, Puerto Rican, etc.) 19. Specify: 14. RACE — American Indian, 15. Black, While, etc. 15. Sectiv:								
р ву	3 My Wildowed 4 Divorced 8 ACK								
ETED	15. DECEDENT'S EDUCATION (Specifly only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4 or 5 +) Coflege (1-4 or 5 +)								
COMPL	8th GRAde Donestie								
BE CO	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surreme)								
TO B	196. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Fourte Number, City or Town, State, Zip Code) 9901 MINI A MILL								
	20e. METHOD OF DISPOSITION 1. Burlai 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetapy-crematory of other place)								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY								
	Joseph B. Locks & Rocks Duneral Home 1304 in Central Mr								
	23. PART f. Enter the diseases, or complications that ceused the death- Do not enter the mode of dying, such as cardiec or respiratory erreat, abock, or heert fellure. List only one ceuse on each line.								
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Onset end Desth								
	DUE TO 10 THE A CONSEQUENCE OF THE LIVE RELIGIANTICAL								
NO!	Sequentially list conditions, If any, leeding to immediate								
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury								
CERTIFICATION	that initiated events reaulting in death) LAST								
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
MEDICAL	PERFORMED? AWAILABLE PRIOR TO								
ME	1 TES 2 NO								
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
PHYSICIAN	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inputient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. MANNER OF DEATH 286. DATE OF INJURY (Month, Day, Year) 286. ITIME OF INJURY AT WORK? 1 Pending 486. DATE OF INJURY 1 VES 2 NO								
р ву	2 Accident 3 Suicide 6 Could not be 2sa. PLACE OF INJURY — At homa, farm, street, factory, office building, stc. (Specify) 2sa. PLACE OF INJURY — At homa, farm, street, factory, office City or fown, State)								
ETED	4 Homicide determined								
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) and manner ee stated. 2 MEDICAL EXAMINER: On the base of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(e) and menner ee stated.								
8	296, SIGNATURE AND TITLE OF CENTIFIED D. Day, Mary								
2	98. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	ELMO M. GAYOSO, M.D./273-F PENINSULA FARM RD/ARNOLD, MD21012								
- #	TOTAL 2 1994 Shull diwater and the								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTME			MENTAL HYG				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT		3. TIME OF DEATH		
		AE MEACHAM			Dec.	7 10	794 9:30 PM			
	213-30-6093	6. AGE (In yrs. In	YRS. IF U	HS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTY (Mooth, Day, Ye 2/29/	34	a. BIRTHPLACE (State or Foreign Country) N. Carolina		
m	99. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Stella Maris Hospice Towson Baltimore									
<u>E</u>	RESIDENCE OF DECEDENT	<u> </u>	В	altimore						
DIRECTOR	Maryland Bal	timore	10c. CITY, TOV	on Local				10d. INSIDE CITY LIMITS? 1 YES 2 100		
FUNERAL	3409 Washington	n Avenue		101	21244		10g. CITI	10g. CITIZEN OF WHAT COUNTRY?		
NS		2. WAS DECEDENT EVER IN U.S. A			ENDENT OF HISPAI	VIC ORIGIN? (Speci		t4. RACE — American Indian.		
B⊀	1 Never Merried 2 Merried 3 XWidowed 4 Divorced	FORCES? t YES 2 X	NO	If yes, sp		in, Puerlo Ricen, etc		Specify: Black		
回	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted) (PECEDENT'S USUA	one durina mo	ON st of working	16b, KIND O	F BUSINESS/IND	DUSTRY		
COMPLETED	Elementary/Secondary (0-12) 12th	ndary (0-12) College (1-4 or 5+) life. Do NOT use retired.)					N/	A		
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, M				
BE (Sherman Hawkin				Lilli					
5	190. INFORMANT'S NAME (Type/Print) Pearlyne Johnso				nd Number or Rural	Route Number, City of Baltin		,		
ľ	20a METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remova	20b. PLACI	FANDDATEOFDIS	POSITION /Na	ment	DATE 20	c LOCATION —	City or Town State		
	4 Donation 3 Other (Specify)	Crow	nsvill	e Vet	CEm.	12/13	rowns	ville, MD		
	22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERIJI HOME									
_	23. PART 4 Eater the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
Ī	shock, or heart failure. Lis	nplications that caused the d it only one cause on each lin	leath. Do not er	iter the mo	de of dying, auc	h aa cardiac or i	reapiratory arr	Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)									
	DUE TO (OR AS A CONSEQUENCE OF):									
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4	PART ii. Other significent conditions of	contributing to deeth but not	resulting in the	underlyln	ceuse given in		S AN AUTOPSY REORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
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W	DID TOBACCO USE CO	ONITRIBILITE TO CAL	ISE OF DE	ATL V	EC PM NO		,	t 🗍 YES 2 🗍 NO		
IAN	25. WAS CASE REFERRED TO MEDICAL	JAIRIBUTE TO CAL	JSE OF DE		ACE OF DEATH (Ch					
VSIC	1 TYES 2 NO 1	OSPITAL: Inpatient 2 ER/Outpatient		IER: Nursing Hom	e 5 🗆 Residence	6 (XOther (Specify	HOSP	ICE		
	27. MANNER OF DEATH Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY		RK?	28d. DESCRIBE H	OW INJURY OC	CURED		
BY	2 Accident Investigation	28e PLACE OF INJURY — At home farm street tectory office						or Bural Boute Number		
COMPLETED	4 Homicide determined	building ate /Soaciful								
PE	29e. CERTIFIER (Check only (Ch									
Ŏ.	one) 2 MEDICAL EXAMINER:	one)								
BE C	29b, STANATURE AND TITLE OF CERTIFIER	29b, ST NATURE AND TITLE OF CERTIFIER								
5	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF PEATURE	EM 27 CE		200	643	▶ 18	18/74		
	DR. KENDALL FAULKNE			ROAL	TOWSON	, MD 212	204			
	31. DATE FILED (Month, Day, Year)	III REGISTRAR'S SIGNATURE				•				
	DEC1 2 1994 Julia	Studen Radall								

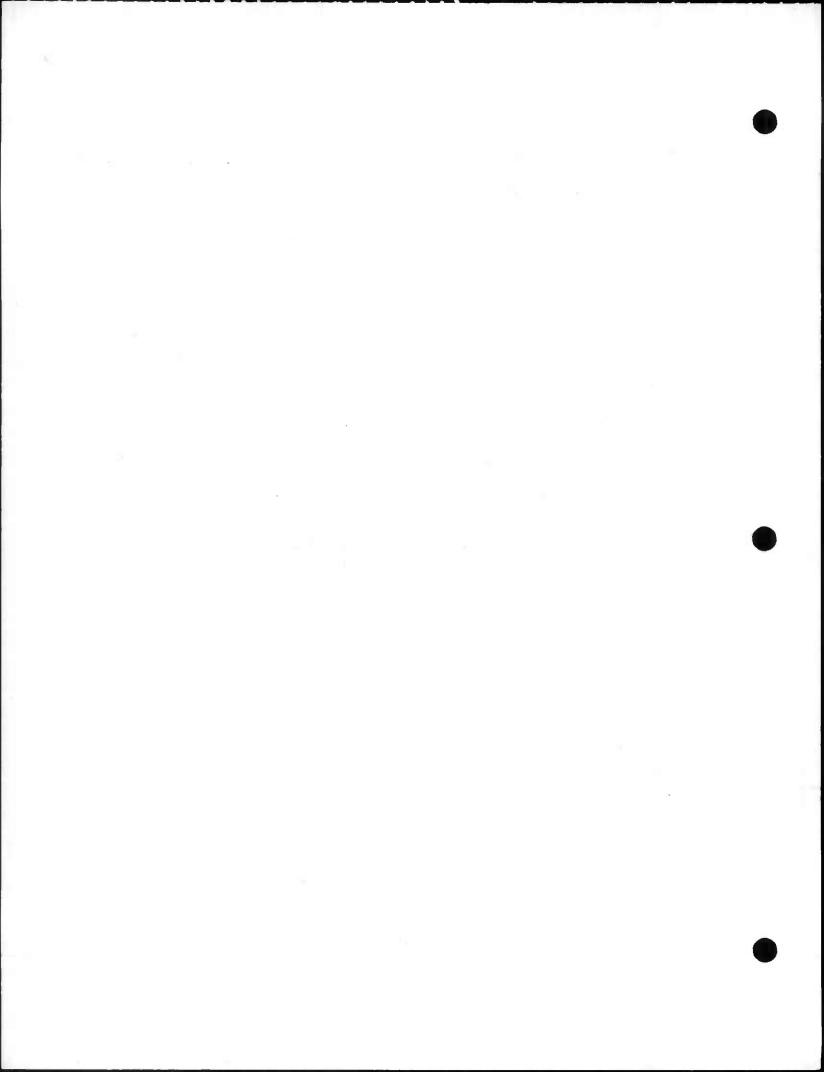


BALTIMORE, MARYLAND 21215-0020 uss after death, Pane 6 may be retained by the broaden or attending physicial

DIVISION OF VITAL RECORDS, P.O. BOX 68760

and be established by the subspicial of the subs	The committants has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	removal.	marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL HYGIEI			
1	1. OECEDENT'S NAME (First, Middle, Lest) SHEFFORD	BERN	MI	NTER		2. DATE OF DEATH MONTH DECEMBER		YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 224-16-1701	1 x M 2 □ F 7		MONTHS DAVE MONTHS MAN (Month, Day, Year) Country)					
H.	9a. FACILITY NAME (If not institution, give s 310 E. LORRAINE		9		TIMORE C		9c. COUNT	Y OF OEA	гн
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	RESIDENCE OF DECEDENT				,111			
E I	MARYLAND			TOWN OR LOCAT LTIMORE				170	INSIDE CITY LIMITS? YES 2 NO
ZAL 3	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZE		AT COUNTRY?
FUNERAL	310 E. LORRAINE	AVENUE 12. WAS DECEDENT EVER IN	NIII ADMES	L	21218			USA	
BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 VES IF YES, GIVE WAR OR DO WW II	N U.S. AHMED 2 ∏NO ATES	If yes, sp		NIC ORIGIN? (Specify Youn, Puerto Rican, etc.) y:	e or No— 1	Black, V Specify:	American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during mo		16b. KIND OF BI	JSINESS/INOU		WILLE
MPLI	12th Grade	College (1-4 or 5+)	Nationa	al Guar	đ	Sr. Ma	aster :	Sgt.	E9
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide			
BE	LEWIS JENNINGS N 19a. INFORMANT'S NAME (Type/Print)	IINTER	19b. MAILING A	ODRESS (Street a		EE FRANKLI Route Number, City or To		`odel	
٩	LEWIS MINTER			3RD SI		STON, PA	18047		
	20a. METHOD OF DISPOSITION 11. Burlel 2 Cremetion 3 Ram 4 Donetion 5 Other (Specify)	noval from State cem	PLACE AND DATE OF	DISPOSITION (Na	me of	OATE 20c. L	OCATION — CI	ty or Town	
ı	21. SIGNATURE OF FUNERAL SEIDNET LI		OUDON PAR		ERY I		ALTIMO	RE, I	MD
	1/1/1				ON FUNER				
\neg	23 PART I, Enter the diseases, or	complications that caused	tha death. Do not	antar tha mo	LOCH_RAV	EN BLVD. h as cardiac or resp	TOWSOI piratory arrai	N_MI at,	21286 Approximata
1	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. OUE TO (OR AS A	indry	بدلم_	lure				intarval Between Onset and Death
z		OUE TO (OR AS A	CONSEQUENCE OF	ISEQUENCE OF:					
ET I	Sequentially list conditions, if any, leading to immediata cause, Entar UNDERLYING DUE TO (OR AS A CONSCOUENCE OF): A CONSCOUENCE OF):								
CERTIFICATION	AUSE (Disease or injury nat initiated events sesulting in death) LAST								
CER	resulting in death) CAST	d							
¥.	PART II. Other significant condition	na contributing to death be	ut not reaulting in	tha undarlying	g cause givan in	Part i. 24a. WAS AI PERFO	RMED?	AV CC	ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONT	PIRLITE TO CALISE O	E DEATH YES		UNCERTAIL			1	YES 2 NO
NA N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH		ONCERIAII	1 🗆			
YSIC	1 TYES 2 NO	HOSPITAL: 1 inpatient 2 ER/Outp.		THER: Nursing Hom	5 🗆 Residence	6 Other (Specify)			
H	27. MANNER OF DEATH 1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME C	Y WO	RK?	28d. OESCRIBE HOW	INJURY OCCU	RED	
2 Accident Investigation " 1 YES 2 NO							and Number or	r Rural Rout	e Number,
COMPLETED		ICIAN: To the best of my knowl							od mannar es stetad
N C	29b. SIGNATURE AND TITLE OF CERTIFIE				29 LICENSE NUR	ABER			onth, Day, Year)
9	30. NAME AND AGORESS OF PERSON WH	IO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type. Pri	int)	W 53	272	1	718	74
1									
	31. DATE FILED (Month, Day, Year) DF C 1 2 1994	32. REGISTRAR'S SIGNA	Randall			-			

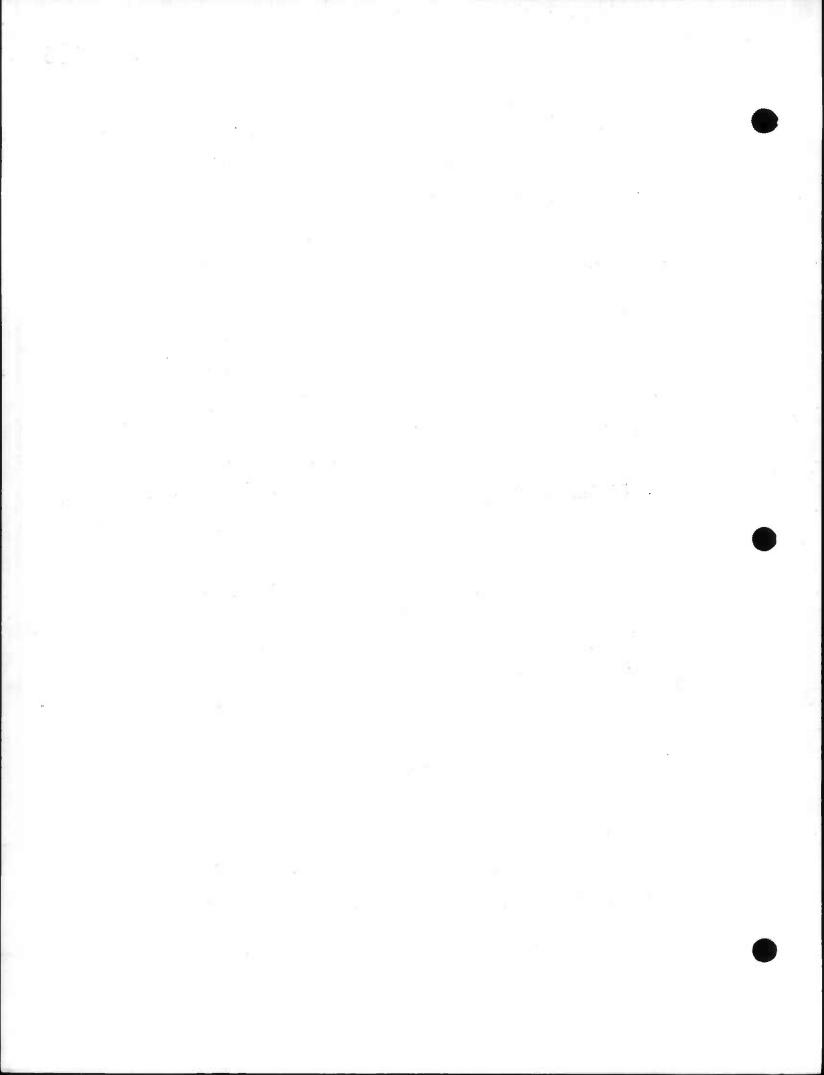


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

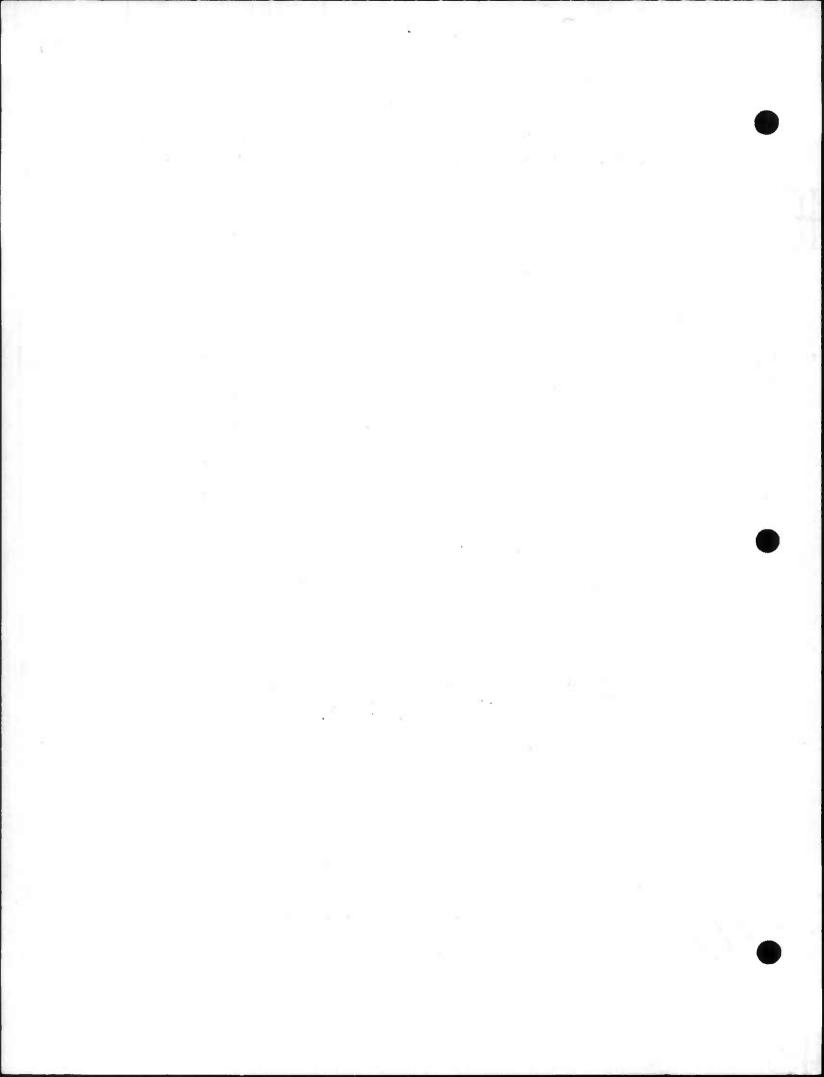
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL	HYGIEN REG. NO.				
	1. OECEOENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH		3. TIME	OF DEAT	Н
	MARY VICTORIA	NORKUS				DEC.			4 10:	20	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH Day, Year)	6.	BIRTHPLACE (State or Fo	reign
	216-32-0499	1 □ M 2 🔀 F	HOURS MIN.		15,		Country)	Md.			
	Se. FACILITY NAME (If not institution, give	street and number)	9	b. CITY, TOWN O	R LOCATION OF D			9c. COUNTY			
5	Stella Maris Hos	pice		To	wson			Balt	imore		
<u> </u>	10e. STATE 10b. COUNT		10c. CITY	TOWN OR LOCAT	ION				104 114	SIDE CITY	
DIRECTOR	Md. Ba	ltimore	3,500.011.1,		10.1				LI	MITS?	
	10e. STREET AND NUMBER	remore			WSON ZIP COOE			100 CITIZEN	OF WHAT CO	ES 2 🔀	NO
FUNERAL	2300 Dulaney Val	lev Rd.		2	1204				S.A.		
S	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED		ENDENT OF HISPA	NIC ORIGIN?	(Specify Yes		RACE Ame	ricen India	in.
	1 Never Married 2 Merried	FORCES? 1 YES			city Cuban, Mexico		can, etc.)		Black, White, Specify:	etc.	
Э ВУ	3 Widowed 4 A Divorced									ite	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grad	ICATION s completed)	16e. DECEDENT'S US (Give kind of wor	k done during mo:		16b. I	KIND OF BUS	SINESS/INOUS	RY		
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use r								
M	17. FATHER'S NAME (First, Middle, Last)	2	Home Mak	er	_		Own Ho	Α			
					16. MOTHER'S NA						
8	Joseph 19a. INFORMANT'S NAME (Type/Print)	Gensavi			Victor:				olffe		
일		a									
1 1	Mrs. Victoria M. 20m. METHOD OF OISPOSITION	201	. PLACE AND DATE OF		cis Rd.	TOWS		1. 2128			-
	1 Burlet 2 M Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State cen	netary, crematory or other	r place)		1		,		•	
	21. SIGNATURE OF FUNERAL PERVICE L	сенрац/	lltop Ser		D AODRESS OF FA		41 10	owson,	Md.		
	> Minhall	11).16		Ruck	Towson :	Funera	al Hor	ne Inc.	,		,
\vdash	22 BADT I Enter the disease of	LELLEYC.		1050	York Rd	. Tows	son, l	4d. 212	204		
	23. PART I. Entar the diseases or shock, or haart failure.	List only one cause on a	ach lina.				ac or raspi	ratory arrest	In	pproxima itarval Be	tween
	IMMEDIATE CAUSE (Final disease or condition	_	ENSTOVE	seefer	ahis	var.			0	nset and	Death
	reaulting in death)	8	CONSEQUENCE OF):								
_									i		
CERTIFICATION	Sequantially list conditions,	OUE TO (OR AS /	CONSEQUENCE OF):								
S	cause. Entar UNDERLYING CAUSE (Disease or injury	c									
[[that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):								
E	resulting in daeth) LAST	d									
AL C	PART II. Other algnificant condition	ns contributing to death t	out not reaulting in	the undariying	cause given in	Pert I.	He. WAS AN	AUTOPSY	24b. WERE A	UTOPSY FI	NOINGS
실	// /:	11	0.57		815.12		PERFOR	MED7	AWAILAB	ILE PRIOR T	no
MEDIC	1/2012111	Algreham	dice	2		= 1	AEB 3	_ NO	OF DEA	THT	
									101	18 2 N	°
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF DEATH (CA	teck only one	_				-
Sic	1 YES 2 NO	HOSPITAL:	sellent 3 DOA 4	THER	5 🗆 Residence	a [] Other	Specific				
ξl	27. MANNER OF DEATH	28s. DATE OF INJUSTY (Month, Day, Yes)	286 TIME C	OF JOE INJ	RY AT	A concentration of the second	PERSONAL PROPERTY AND ADDRESS OF THE PERSONS ASSESSMENT AND ADDRESS OF THE PERSONS ASSESSMENT AND ADDRESS ASSESSMENT AND ADDRESS ASSESSMENT ASS	NURY OCCUR	ED		-
ВУБ	1 Matural 5 Pending 2 Accident Investigation	(morest bag year)	/ 10001	The second of th	E5 2 NO	100000000000000000000000000000000000000					
ED B	3 Suicide 8 Could not be	28s. PLACE OF INJURY building, etc. Toxic	At tyone, farm, stre	et, factory, office		28F. LOCAT	TION (Street of Town, State)	nd Number or F	Aural Plante Non	704(\neg
111	4 Homicide determined		/			Lity di	count, School				
2	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	ledge death occurred	at the time, date	and place, and due	to the cause	ejs) and man	ner as stated.			
COMPLET		ER: On the basis of examination							use(x) and ma	onner as st	ated.
	295. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI	797.7 - 11	/		GNED /Month,		11000
BE (The second secon				1/15	504	r.	D16.	8 98	-	
1	30. NAME AND AODRESS OF PERSON WE	10 DOMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pr 2 300	Helson	7 041	7 1	4	2160	6		\neg
	31. DATE-FILED (M. 10. 10. 10. 10. 1	In Broker for	halle								-
	DE01 2 100 1										



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CIAN: The law requires that the death certificate be executed within mours after death	Ě	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN	E		
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATH		3. TIME OF DEATH	
	(ZEUVOIP H	O'Canni	0.11		ма С нтиом	7 94	9:50 AH	
		SEX 6. AGE (In yrs. last birthday) F	UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign	
	217 22 7682 1	M2 □ F 6	7 YRS. MOI	ITHE DAYS HOURS MIN.	9/25/2	8 Ma	ryland	
	Se. FACILITY NAME (If not institution, give street	and number)	9b	CITY, TOWN OR LOCATION OF		9c. COUNTY OF		
S.	VA Hospital			Baltimore				
DIRECTOR	RESIDENCE OF DECEDENT							
IR.				OWN OR LOCATION			10d. INSIDE CITY LIMITS?	
	MD Balt:	imore	Balt	imore Highl	ands		1 TES 2 NO	
BA	The second straining of the second se			101. ZIP COOE			WHAT COUNTRY?	
FUNERAL	2815 Alabama Ave			21227		U.S.Z		
F	1 Never Married 2 Married	P. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO	13. WAS DECENOENT OF HISP If yes, specify Cuben, Mex	cen, Puarto Rican, etc.)	or No — 14. RAC Blac	CE — American Indian, ok, White, etc.	
B	3 Widowed 4 XDivorced	1/45 - 9/		1 TYES 2 NO Spe	clfy:	Spe	white	
8	15. DECEOENT'S EDUCATE	ION	18e. DECEDENT'S USL		16b. KIND OF BUS	INESS/INDUSTRY	WILLCE	
COMPLETED	(Specify only highest grade corr Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during most of working ired.)				
19	10		Seaman		Mercha	nt Mar:	ine	
5	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First, Middle, Maiden			
BE (Samuel O'Connel:	1		Ida D	orsey			
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and Number or Run	al Route Number, City or Town	n, State, Zip Code)		
	Dick O'Connell		3019 M	ichigan Ave	nue, Balt	imore,	MD 21227	
	20a_METHOD OF DISPOSITION 1 Description 2 Cremation 3 Removal	from State com	.PLACE AND DATE OF Dietery, crematory or other	olago)		CATION — City or T		
	4 Donetion 5 Other (Specify)	M	eadowrid	ge Mem. Par	k 12/12 D	orsey,	MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	7	0				ofLansdowne	
	2 hold Jo	1	- 771		_		owne,MD2122	
1	23. PART I. Enter the diseases, or com shock, or heart fellure. List	iplications that caused tonly one cause on e	the deeth. Do not each line.	enter the mode of dying, se	ich as cerdiec or reepi	ratory arrest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel						Onset and Death	
	diseese or condition resulting in death)	Aspirati	on Phei	monia r Disease				
		BUE TO (OR AS A	CONSEQUENCE OF):	0.				
NO	Sequentielly liet conditions, b	DUE TO (OR AS A	JONSEDHENCE OF	r Visease				
ΙĘΙ	If any, leading to immediate	(/ /	ounded de la			1		
	cause. Enter UNDERLYING	cause. Enter UNDERLYING CAUSE (Disease or Injury						
IFICA	cause. Enter UNDERLYING	OUE TO (OR AS A	CONSEQUENCE OF):					
RTIFICA	cause. Enter UNDERLYING CAUSE (Disease or Injury	OUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST d							
AL A	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions or	ontributing to death b	ut not resulting in th	ne underlying ceuse given	in Pert I. 24a. WAS AN. PERFOR	MED?	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
A P	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions or	ontributing to death be	ut not resulting in the	inguffirm	in Pert I. 24e. WAS AN PERFOR	MED?		
AL A	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions or	ontributing to death be	ut not resulting in the	insufficiency COPD	in Pert I. 24a, WAS AN. PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
AL A	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significent conditions or right heart for dia betes, Coverna DID TOBACCO USE CO	ontributing to death be	ut not resulting in the	insufficiency COPD EATH YES NO	PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AL A	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions con in the heart for draphetes, Coverna DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL	ontributing to death by a large of the other	ut not resulting in the price prevail to the prevai	EATH YES NO	PERFOR 1 YES 7	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
A P	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions con in the heart for draphetes, Coverna DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL	ontributing to death by a live, chymnory NTRIBUTE TO (ut not resulting in the control of t	EATH YES NO. 26. PLACE OF DEATH (THER: Nursing Home 5 Residence	PERFOR 1 YES 2 Check only one) 8 Other (Specify)	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions or Cight heart for DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Setural 5 Pending	ontributing to death by a large of the other	ut not resulting in the price prevail to the prevai	EATH YES NO 26. PLACE OF DEATH (THER: Nursing Home 5 Residence 28c. INJURY AT WORK?	PERFOR 1 YES 7	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions of the heart for discrete better conditions of the heart for DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Setural 5 Pending Investigation	ontributing to death by the characteristic of the characteristic o	ut not resulting in the control of t	EATH YES NO 26. PLACE OF DEATH OF THER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO	PERFOR 1 YES 2 Check only one) 8 Other (Specify) 28d. DESCRIBE HOW IN	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions or the test of	ontributing to death be clevely Chron NTRIBUTE TO COSPITAL: Appetition 2 = ER/Outp 28e. DATE OF INJURY	ut not resulting in the control of t	EATH YES NO 26. PLACE OF DEATH OF THER: Nursing Home 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO	PERFOR 1 YES 2 Check only one) 8 Other (Specify)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions of the beta Coverned DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Setural 5 Pending Investigation 3 Suicide 4 Homicide detarmined	OSPITAL: 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec	cause of Distinct a large street of the large	EATH YES NO 26. PLACE OF DEATH (THER: Nursing Home 5 Residence WORK? M 1 YES 2 NO I, factory, office	PERFOR 1 YES 2 Check only one) 8 Other (Specify) 28d. DE\$CRIBE HOW IN City or Town, State)	NON NORTH OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions of the beta Coverne DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Setural 5 Pending Investigation 3 Suicida 8 Could not be detarmined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN	ontributing to death by the characteristic of the characteristic o	cause of Distinct 3 Doa 4 Doa 1 Doa	EATH YES NO 26. PLACE OF DEATH (THER: Nursing Home 5 Residence WORK? M 1 YES 2 NO 1, factory, office	PERFOR 1 YES 2 Check only one) 8 Other (Specify) 28d. DESCRIBE HOW IN 26f. LOCATION (Street at City or Town, State)	NJURY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
COMPLETED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions of the beta Coverne DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Setural 5 Pending Investigation 3 Suicida 8 Could not be detarmined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN	ontributing to death by the characteristic of the characteristic o	cause of Distinct 3 Doa 4 Doa 1 Doa	26. PLACE OF DEATH (THER: Nursing Home 5 Residence WORK? M 1 YES 2 NO t, factory, offica the time, date end place, and d my opinion, death occured at ti	PERFOR 1 YES 2 Check only one) a S Other (Specify) 28d. DESCRIBE HOW IN 28d. LOCATION (Street a City or Town, State)	NON NO NUMBER OF RURAL OF THE STATE OF THE S	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions or A CA BE LES, COVERNO DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicides 1 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O	ontributing to death by the characteristic of the characteristic o	cause of Distinct 3 Doa 4 Doa 1 Doa	EATH YES NO 26. PLACE OF DEATH (THER: Nursing Home 5 Residence WORK? M 1 YES 2 NO 1, factory, office	PERFOR 1 YES 2 Check only one) a S Other (Specify) 28d. DESCRIBE HOW IN 28d. LOCATION (Street a City or Town, State)	NON NO NUMBER OF RURAL OF THE STATE OF THE S	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
E COMPLETED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions or A CA BE LES, COVERNO DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicides 1 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O	OSPITAL: Apatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Control of the basis of examination the basis of examination	ut not resulting in the control of t	EATH YES NO 28. PLACE OF DEATH (HER: Nurning Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO 1, factory, offica the time, date end place, and d my opinion, death occured at t	PERFOR 1 YES 2 Check only one) a S Other (Specify) 28d. DESCRIBE HOW IN 28d. LOCATION (Street a City or Town, State) us to the cause(s) end men the time, data and placa, and UMBER	NJURY OCCURED Ind Number or Rurel Iner as stated, d due to the ceuse 29d. DATE SIGNEI	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) end menner as stated. D (Month, Day, Year)	
BE COMPLETED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions or I OTHER SIGNIFICENT CONDITIONS DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicida S Could not be detarmined 29. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: O 29. SIGNATURE AND TITLE OF CERTIFIER	OSPITAL: Apatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Control of the basis of examination the basis of examination	ut not resulting in the control of t	EATH YES NO 28. PLACE OF DEATH (HER: Nurning Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO 1, factory, offica the time, date end place, and d my opinion, death occured at t	PERFOR 1 YES 2 Check only one) a S Other (Specify) 28d. DESCRIBE HOW IN 28d. LOCATION (Street a City or Town, State) us to the cause(s) end men the time, data and placa, and UMBER	NJURY OCCURED Ind Number or Rurel Iner as stated, d due to the ceuse 29d. DATE SIGNEI	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) end menner as stated. D (Month, Day, Year)	
BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST PART II. Other significent conditions of the part of	OSPITAL: Apatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Control of the basis of examination the basis of examination	ut not resulting in the state of the state o	EATH YES NO 26. PLACE OF DEATH (HER: Nursing Home 5 Residence 26c. INJURY AT WORK? 1 YES 2 NO 1, factory, offica the time, date end place, and d my opinion, death occured at ti	PERFOR 1 YES 2 Check only one) a S Other (Specify) 28d. DESCRIBE HOW IN 28d. LOCATION (Street a City or Town, State) us to the cause(s) end men the time, data and placa, and UMBER	NJURY OCCURED Ind Number or Rurel Iner as stated, d due to the ceuse 29d. DATE SIGNEI	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) end menner as stated. D (Month, Day, Year)	



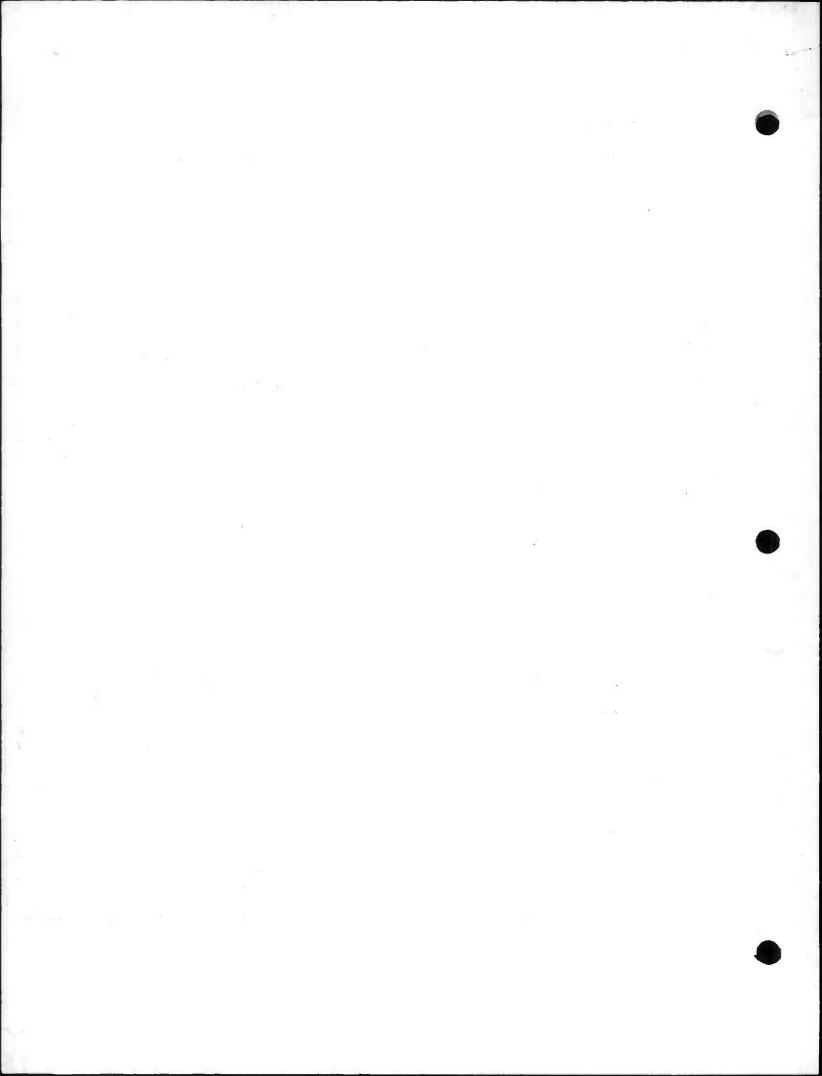
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burgatran

		1 - STATE REGISTRAR	STATE OF MARYL	AND /	DEPAR	TMENT	OF H	IEALTH DE A	AND I		HYGIENI REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last)	Fay E		Pay					2. DATE OF MONTH		199	AR	TIME OF OEATH
		4. SOCIAL SECURITY NUMBER 212-12-5357	1 🗆 M 2 😾 F	(In yrs. las	st birthday) YRS.	IF UNDER	DAYS	HOURS	R 24 HRS.	7. DATE OF MAR	BIRTH	919	BIRTHPL Country) MD	
	СТОВ	9e. FACILITY NAME (If not Institution, give street and number) 1213 Ramblewood Road BESIDENCE OF DECEDENT 9b. CITY, TOWN OR LOCATION OF DEATH Balto										тн		
	DIRE	MD 10e. STREET AND NUMBER				y, town o							Х	Od. INSIDE CITY LIMITS? YES 2 NO
	FUNERAL	1213 RAMBLEWO	OOD RD				101	212				10g. CITIZEN	OF WHA	AT COUNTRY? A.
	В	11. MARITAL STATUS 1 Never Married 2 Married XX Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X N			f yes, sp		en, Maxica	NIC ORIGIN? (S in, Puerto Rica y:		or No.— 14.		American Indian, White, etc.
	PLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) Callege (1-4 or 5+)	(Gi	CEDENT'S live kind of v Do NOT us	work done o			ing		ND OF BUS	OF I		CATION
once.	COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, Midd	dle, Maiden S	Surname)	JD C .)NI I OII
76	BE	ALBERT HALL 19e. INFORMANT'S NAME (Type/Print)		194	- *** 1110	1000000	101-mad a		RMEN			CHELL		
e notified	2	PHYLLIS HALL) 212]		
or must be		20s. METHOD OF DISPOSITION 1 Guriel 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify)	oval from State cen		AND DATE OF	MOR'	CAL	PK				CATION — CHY		
oval.		21. SIGNATURE OF FUNERAL SERVICE LICE	A. Hor	nPS	ion		4300	O W		h Aven		alto, I		1215
event, the medical e		23. PART Inter the diseases, or combook, or heert failure. Limmediate Cause (Finel disease or condition reculting in death)	e. DUE TO (OR AS A	each iine				de of dy	ing, suci	h es cardied	or reepir	atory srreet,		Approximate Interval Between Onset and Death
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events b. ACVE MYOCARDAL INFALORD OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):									/who we			
ntal my	CERI	resulting in deeth) LAST	J							_				
hows any in	MEDICAL	MARKIENZIAN	1 U Y					PERFORM	PERFORMED?		ERE AUTOPSY FINDINGS ARLABLE PRIOR TO OMPLETION DF CAUSE OBATH? YES 2 NO			
m 23 s	NAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL			TH YE			UNC	CERTAIN	<u> </u>				
or item	HYSICI/	1 TES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3	□ DOA	OTHER	l: ing Hom	5 MA	asidence	8 🗌 Other (S)	pecify)			
marked,	<u>-</u>	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	(Month, Day, Year)		28b. TIMI INJ	E OF URY M	-	URY AT PK? (ES 2	No	28d. DEŞCRI	IBE HOW IN	JURY OCCURE	D	
28 is	ETED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY building, etc. (Spec	f — At hor	me, farm, s	street, facto	ory, offic	•		28f. LOCATIO	ON (Street er fown, State)	nd Number or R	tural Rout	e Number,
2 =	COMPLE	2 MEDICAL EXAMINER	CIAN: To the best of my know R: On the bests of examination										use(s) en	nd manner as stated.
	O BE (29b. SIGNAT HIS HIS TITLE OF CERTIFIER	to MD					29c. LIC	ENSE NUM	BER 85		29d. DATE SIG	GNED (MC	onth, Day, Year)
		AND LEVITY M.D			M 27) (Type,		NE	B	ALTI	More	, n	0	212	.01
)		DEC1 2 1994 July	REGISTRAF SIG	AMRE										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages to filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
O THE HOSPITAL OR ATTENDING PHYSICIAN: The 18	O THE FUNERAL DIRECTOR: After this certificate has e filed within 72 hours after death with the State De	MPORTANT: If Item 28 is marked, or Item 2

	FOR CT	ATE OF MARY AND					J 49	00	043	
	1 - STATE REGISTRAR	ATE OF MARYLAND	ERTIFIC			MENTAL HYGIEN REG. NO	_			
Ŋ	1. DECEDENT'S NAME (First, Middle, Last)	0				2. DATE OF DEATH	AY Y	3. 1	TIME OF DEATH	A
		PERDUE				12	8 9	4	0:900	W
	4. SOCIAL SECURITY NUMBER 5. SI			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLA	CE (State or Foreign	
	2)/ 0/ 2)70	M 2 D F 87	YRS.			July 19,1	907	Vinoi	nia	
	9e. FACILITY NAME (If not institution, give street en		96	. CITY, TOWN O	R LOCATION OF DE	EATH	9c. COUNTY	OF DEATH		
6	Harbor Hospital (.enter		Baltimo	re					
2	10e, STATE 10b, COUNTY		10c CITY TO	OWN OR LOCAT	ON			1 404	. INSIDE CITY	
DIRECTOR	Maryland =====	_		Limore					LIMITS?	
	10e. STREET AND NUMBER		Duce		ZIP CODE		10g. CITIZE		YES 2 NO	
FUNERAL	1509 Locust Street	<u>L</u>			21226			S.A.	COUNTY	
5	11. MARITAL STATUS 1 Never Merried 2 Merried	MS DECEDENT EVER IN U.S. A ORCES? 1 YES 2	RMED			NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	e or No 14	RACE - /	Americen Indien, lite, etc.	
B⊀	3 X Widowed 4 Divorced	YES, GIVE WAR OR DATES	2107		2 NO Specify			Specify:	White	
COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade comple		DECEOENT'S USU	IAL OCCUPATIO	N t of working	16b. KIND OF BU	SINESS/INDUS		vncce_	\dashv
9	Elementary/Secondary (0-12) Coll	ege (1-4 or 5+)	fe. Do NOT use rel	tired.)	t or working					
MP	10th		ousewi:	e		Home 1	Naker			
8	17. FATHER'S NAME (First, Middle, Last)			1		ME (First, Middle, Maiden	Surneme)			
BE	unkr		age			Rnown				
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
	Ralph Pendue		128 Vic			Baltimore	, Mary	Land	21225	
	1 Source 2 Cremation 3 Removal tr 4 Donation 5 Other (Specify)		EAND DATE OF DI remategy or either ; It Hill			12/12 Ba	Atimon			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		1			CILITY _		2, 17W	ngxunu	\dashv
	1 Dana M	Bramerso	ushi	4001 9	ey. Gone	ce Funeral Hwy. Balt	Home	P.A.	2/225	
	23. PART I. Enter the diseases, or comptishock, or heart failure. Vist of IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	put TO (OR AS A CONS	na.	enter the mod	la of dying, auc	la d	iretory arrest	i,	Approximate Interval Betwee Onset and Das	
CERTIFICATION	Sequentisliy list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONS								
- 1	PART II. Other significent conditions con	tributing to death but not	resulting in th	na underfying	cause given in	Part I. 24s. WAS AN		24b. WEF	E AUTOPSY FINDING	s
S	Ischemic B	owel Sur	alrus			PERFO		CON	LABLE PRIOR TO IPLETION OF CAUSE	ı
			0 7				L HO		YES 2 NO	- 1
7	DID TOBACCO USE CON	TRIBLITE TO CAL	ISE OF D	EATH V	ES [] NO				1123 2 110	- 1
A	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAC	OL OI D		ACE OF DEATH (Ch					\dashv
Sic		SPITAL: inpetient 2 - ER/Outpetient		HER: Nursing Home	5 Reeldence	6 Other (Specify)				
PHYSICIAN: MEDICAL		28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJU	IRY AT	28d. DESCRIBE HOW	NJURY OCCUR	ED		\dashv
ВУБ	1 Natural 5 Pending 2 Accident Investigation	(MORAI, Day, Ibar)	MJORT	M 1 Y						
	- Included	28e. PLACE OF INJURY — At I building, etc. (Specify)	nome, farm, stree	t, fectory, office		281. LOCATION (Street City or Town, State)		Aural Route	Number,	٦
	29e, CERTIFIER			_			_			4
COMPLETED	(Check only one) 299. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On (Check only one)							euse(e) end	manner ee stated,	
	29b. SIGNATURE AND TITLE OF CERTIFIER						29d. DATE S			\dashv
) BE	Pitayadit	Jumpus BI ETED CAUSE DE DEATH (I	WRIH	-ue	HOUSE S	tall			- 9 4	
유	30. NAME AND ADDRESS OF PERSON WHO COM	CELED ONOSE OF OFFILE	Em zij (iypa, riiti	1)						\dashv
	Pityadet Jumnussin	ikul Hand	bor Hos	pital 3	3001 S. ;	Hanover St	. Balt	0., /	nd. 2122	5



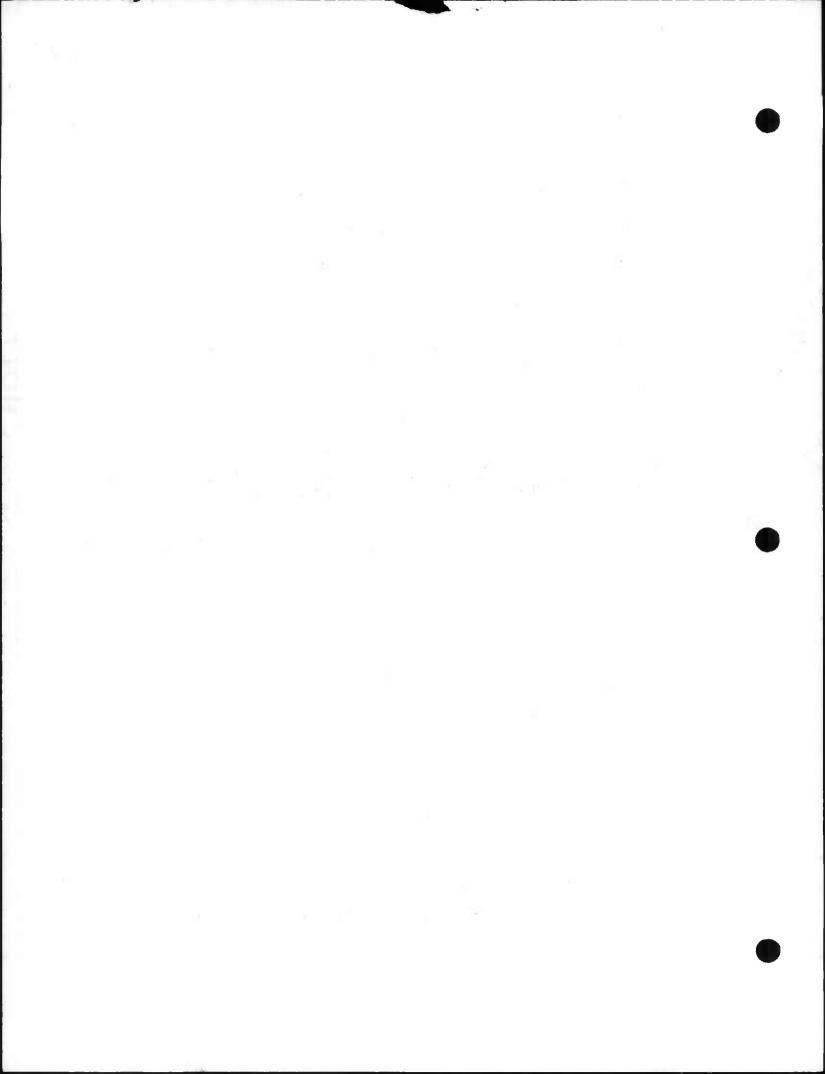
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

CI
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC				ENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					_	2. DATE OF DEATH			3. TIME OF DEA	TH
1	MELVIN L.	PITTS				I			94	1433	Рм
	The second second			F UNDER 1 YEAR	IF UNDER 24	HRS.	7. DATE OF BIRTH (Month, Day, Year)		Count		
	267-60=8817 9e. FACILITY NAME (If not inetitution, give stre	of end number) 9b. CITY, TOWN OR LOCATION OF E					6/23/37			TIMORE,	①.
Œ	1229 NORTH BROA							9c. COUN	TY OF D	EATH	
5	RESIDENCE OF DECEDENT	E C]	T'Y			,					
DIRECTOR	10a. STATE 10b. COUNTY						10d. INSIDE CIT				
	MARYLAND 10e. STREET AND NUMBER		BA	LTIMORE	. ZIP CODE			1		1 X YES 2	NO
FUNERAL	1209 ST. AGNES LA	NF			2-2-12					VHAT COUNTRY?	
N		12. WAS DECEDENT EVER I				HISPANIC	ORIGIN? (Specify Ye	USA or No —	14. RACI	E — American Indi	lan,
BY F	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 X YES	2 NO ATES		ecity Cuben, 2 NO		Puerto Rican, etc.)		Black	k, White, etc.	3 4 3 7
		1956- 1960	18e. DECEDENT'S U				T		AKF	" AMERIC	JAN
ETE	(Specify only highest grade co	(Specify only highest grade completed)					16b. KIND OF BU	SINESS/IND	JSTRY		
IPLI	Elementary/Secondary (0-12)	College (1-4 or 5 +)	HOUSING	AUTHORI	TY OF	BAL	T ASSIST	ANT S	UPE	RVISOR	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHE	R'S NAME	(First, Middle, Maiden	Surname)			
BE (MELVIN PITTS				HAZ	EL	DUNN				
0	19a. INFORMANT'S NAME (Type/Print)			ite Number, City or Tow							
	MARIAN PITTS 200. METHOD OF DISPOSITION					TREE	T, BALTIM				
1 M Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) GARRISON FOREST CEMETERY 12/9/94 OWINGS MILL, MD 1. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							wn, State				
	* Though	M. The	0				FUNERAL	-			
	23. PART I. Entar the ciseases, or co	mplications that cause	the death. Do no	t antar tha mo	da of dylne	PLA	CE, BALTI	ratory arr	MD.	Approxim	ata
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or least fallura. List only one cause on each line. IMMEDIATE CAUSE (Final									atween	
	disease or condition resulting in death)	HYPERTENSI	WE AKTER	HOSCVE	ROTIC	CA	RPIOVASO	ULAR	Di.		
	DUE TO (OR AS A CONSEQUENCE OF):										
NO	Sequantially list conditions, Due to (or as a consequence of):										
CERTIFICATION	If any, laading to immediate cause. Enter UNDERLYING	202 10 (011 23)	CONSECUENCE OF).								
Ĕ	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):							-	
ERI	resulting in death) LAST										
AL C	PART II. Other significant conditions	contributing to death b	ut not resulting in	tha underlying	g cause giv	ren In Pa			24b.	WERE AUTOPSY F	INDINGS
SC	CHRONIC OBS	TRUCTIVE P	LLMONARY	OLSEA	SE		PERFOR			AMILABLE PRIOR	
MEDIC								1		OF DEATH?	NO
	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	□ NO □	UNCE	RTAIN			1		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)							
1YS	1√7, yES 2 □ NO 27. MANNER OF DEATH	28e. DATE OF INJURY	atlent 3 DOA 4	☐ Nuraing Hom	- 4444		Other (Specify)				
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME	Y WO	RK?		8d. DEŞCRIBE HOW I	NJURY OCC	URED		
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, ferm, str			\rightarrow	St. LOCATION (Street	and Number	or Rural F	loute Number,	\dashv
TED	4 Homicide determined	building, atc. (Spec	Hy)				City or Town, State)			,	
COMPLET	29e, CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my know	edge, death occurred	at the time, date	end plece, e	nd due to	the ceuse(e) and mar	ner ee state	d.		$\overline{}$
OM	XX MEDICAL EXAMINER:) end menner ee s	tsted.
29c. LICENSE NUMBER 29d. DATE SIGNE							SIGNED	(Month, Day, Year)	\neg		
TO B	The Contraction	one /	M		0.0	C.M.	E	▶ DE	C.	3,1994	
	MANO + GOLLE	16	итн (ITEM 27) (Туре, Р. 11 Penn		t, B	alt:	imore, M	laryl	and	21201	
- 8	DECT 2 1994 Juli	32. REGISTRAR'S SIGN			-						



TO THE CISPILE OF VITAL RECORDS, P.O. BOX 68760,

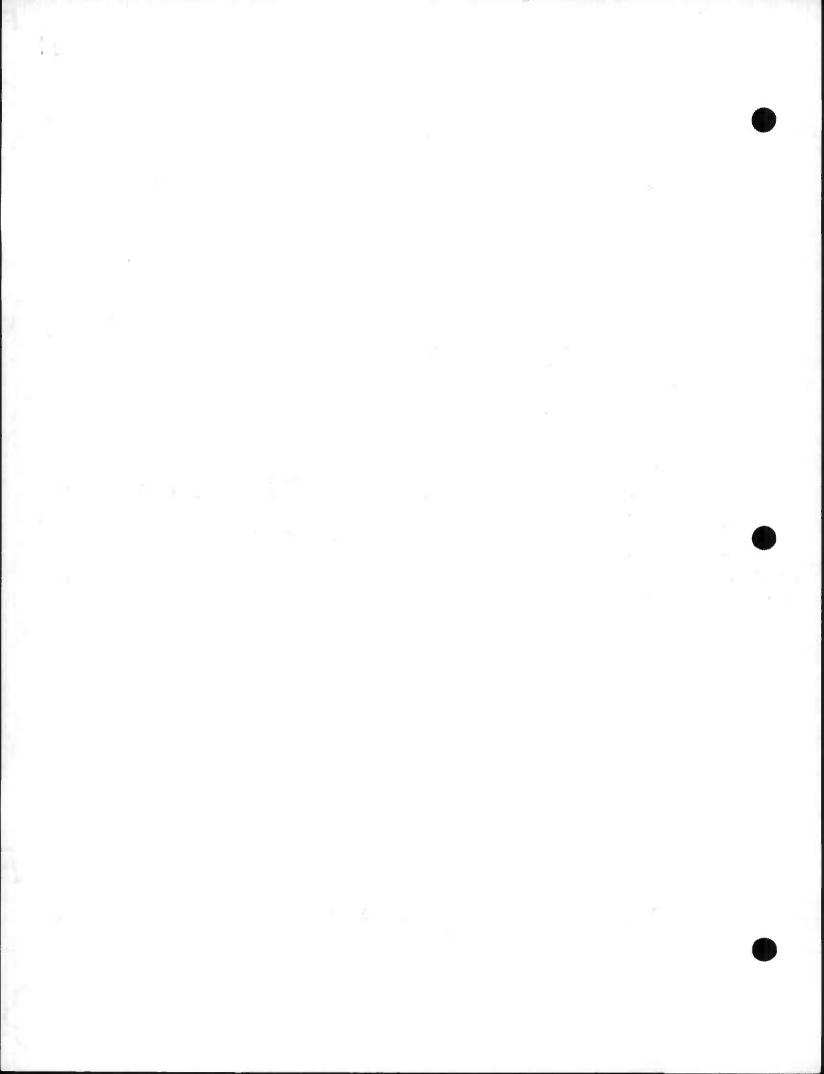
TO THE CISPILE OF VITAL RECORDS, P.O. BOX 68760,

TO THE CISPILE OF VITAL BY SERIES AND PASSIONAL THE LAW REQUIRES THAT THE LAW RECORDS TO THE FUNCTIONAL STATE OF CONTINUE THAT THE CONTINUE OF CONTINUE AND THAT THE CONTINUE OF CONTINUE AND THAT THE CONTINUE AND THE CONTINUE AND THAT THE CONTINUE AND THAT THE CONTINUE AND

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

	7120077777			-11111	OAIL	I DEA		HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Lois E. Price				2. Date of Death Month December				9, 1994 7:45 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 YE	AR IF UNDE	R 24 HRS.	7 DATE OF BURTH A BIG			ACE (State or Foreign
	217-24-7411	1 M 2 X F	65	YRS.	MONTHS DA	ITHE DAVE MOUNTE MAN (MORRY, 7687)			Country)	ylvania	
	9s. FACILITY NAME (If not institution, give si		9b. CITY. TO	VN OR LOCAT				NTY OF DEAT			
Œ	North Arundel Hos							-			
DIRECTOR	North Arundel Hospital Ass'n. Glen Burnie Anne Arun								muei		
Ĭ	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LO	CATION				10	d, INSIDE CITY
ā	Maryland Anne	Arunde1		G16	en Burr	nie				1	LIMITS?
A	10e. STREET AND NUMBER 10f. ZIP CODE 10e. CITIZEN OF WHAT C								T COUNTRY?		
BY FUNERAL	4 Glen Circle					210	61		Unit	ted St	ates
5	11. MARITAL STATUS	12, WAS DECEDEN			13. WAS	DECENDENT	OF NISPANI	C ORIGIN? (Specify Yea	or No-	14. RACE -	American Indian,
7	1 Never Married 2 Married	IF YES, GIVE V	YES 2 X	NO		, specify Cub YES 2 😿 NO		, Puerto Rican, etc.)		Specify:	/hite, etc.
	3 Wildowed 4 X Divorced	113									White
COMPLETED	15. DECEDENT'S EQUE (Specify only highest grade	CATION completed)	(0	live kind of v	USUAL OCCUI	ATION most of work	dng	16b. KIND OF BUS	INESS/INC	DUSTRY	
ш.	Elementary/Secondary (0-12)	College (1-4 or 5	61 1 00	Do NOT us				0			
MP	12		Me	at Wr	apper			Groce	-		
8	17. FATNER'S NAME (First, Middle, Last)							E (First, Middle, Malden	Surname)		
BE	James Gaylor						rl Fu				
2	Ralph N. Price, J	ln						oute Number, City or Town			
- 1		· ~		0031	5ктрја	ICK PI	ace,	Pasadena,			
	20s. METNOD OF DISPOSITION 1 Burlel 2 □ Cremelion 3 □ Remo	oval Irom Stala	comoton, or	amatan, as at	Pher plecel					City or Town	
	4 Donation 5 Other (Special)	<u> </u>	Glen	Have	n Mem.	Pk. [ec. 1	2,'94 Gle	n Bu	rnie,	Maryland
	22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E., Glen Burnie, MD 2										
17	1 Call all	~			421	Crair	Hwv.	S.E. G	len l	c Burnie	MD 21061
	23. PART I. Enter the diseases, or o	omplications the	t coused the de	eeth. Do n	ot enter the	mode of d	ying, euch	ea cerdiec or respi	ratory arr	reet,	Approximeta
	ahock, or heert fellure. I	List only one car	ise on each line	в.		-					Interval Batween Onset and Death
- 1	disease or condition resulting in death) a Dakes D Rectal Caucer										
	DUE TO (OR AS A CONSEQUENCE OF):										
z											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE OF	7):						
5	cause. Enter UNDERLYING CAUSE (Disease or injury	C									
빌	that initiated events resulting in death) LAST	OUE TO	(OR AS A CONSE	OUENCE OF	7):						
H	readiting in death) CAST	s									
	PART II. Other significent condition	s contributing to	deeth but not	resulting I	n the under	ying ceuse	given in P	Part I. 24a. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
EDICAL								PERFOR	MED?	AV	MILABLE PRIOR TO DMPLETION OF CAUSE
8								1 YES 2	X NO	01	DEATH?
2								_		1	YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL					B. PLACE OF	DEATH /Cher	ck only one)			
Sic	EXAMINER? 1 YES 2 Y NO	HOSPITAL:	EB/Outpetlant 1	I DOA	OTHER:			Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	26s. DATE OF	INJURY	28b. TIM	E OF 28c	INJURY AT		28d. DESCRIBE HOW IP	JURY OC	CUREO	
	1 X Natural 5 Pending Investigation	(Month, E	lay, Ybar)	INJ	M 1	WORK? YES 2	□ NO				- 1
ВУ	2 Accident investigation 3 Suicide 6 Could not be	26a. PLACE C	F INJURY — At he	ome, farm, s	treel, factory,	office	- 1	261. LOCATION (Street a	nd Number	or Rural Rout	te Number.
Ë	4 Nomicide determined	building,	etc. (Specify)					City or Town, State)			
COMPLETED	29a. CERTIFIER 1 K CERTIFYING PAYER	CIAN: To the heat of	emu knowledge, de		-d -d 15 - d1						
M P	(Check only one) 2 MEDICAL EXAMINE										
8					n, or my opinio						
BE	29b. SIGNATURE AND TITLE OF CERTIFIER 97										
	2 17 3 Dec. 3, 1994										
	brayle 1	orba	y				-11	- 0			7, 1994
2	30. NAME AND ANDRESS OF PERSON WHO Mayer Gorbaty M	COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type,	Print)				_		
	Mayer Gorbaty, M.	D., 795	Aquahari	M 27) (Type,	Print) Suit				_		
	Mayer Gorbaty, M.	D., 795	Aquahari	M 27) (Type,	Prim) Suit				_		



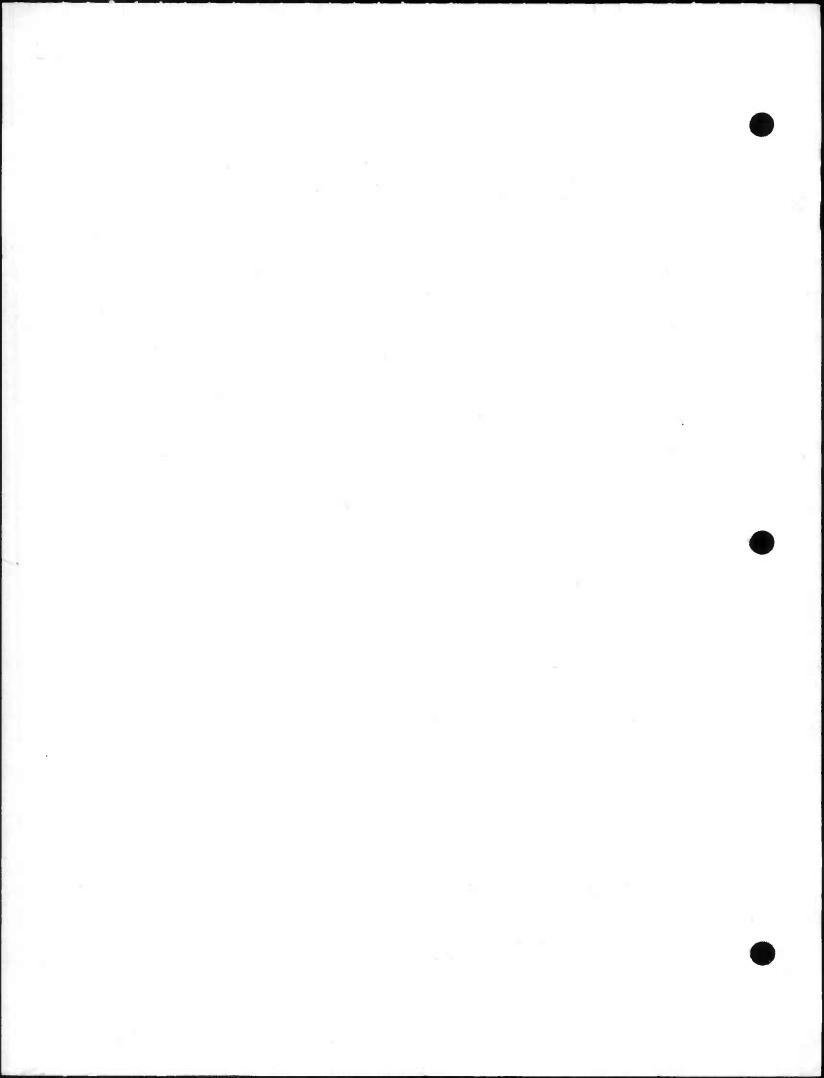
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BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should bit the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
, P.O. BOX 68760,	eath certificate be executed within	certificate has been signed by the attending physician and completely filled in by the the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SPITAL OR ATTENDING PHYSICIAN: The law requires that the di	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the abe filed within 72 hours after death with the State Dept. of Health and Men
	TO THE H	TO THE FL

STATE	0F	MARYLAND	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGI	ENE
		C	ERTIFICATE	0	F DEAT	TH		REG	NO

	1 - STATE REGISTRAR	STATE OF MARYLAND / DEP CERT	PARTMENT OF HEAD		AL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) MARLENE L	. PRICE		MON		S. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthd		UNDER 24 HRS. 7. DAT	Z 7- E OF BIRTH nth, Day, Year)	8. BIRTHPLACE (State or Foreign				
	216-52-3031 9a. FACILITY NAME (If not institution, give str	1 DM 2 XF 45 YR		8/	23/49.	country) ma				
S S	11 11	PITAL CENTER	96. CITY, TOWN OR LO	1 MORE		ALTIMORE				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		PITY, TOWN OF LOCATION			10d. INSIDE CITY				
	Ma		12a 1 to			1 YES 2 NO				
FUNERAL	251 Seamo	n Ave	101. ZIP	1225	10g. Cf	TIZEN OF WHAT COUNTRY?				
	11. MARITAL STATUS 1 Nover Married 2 Married	12. WAS DECEDENT EVER IN U.S. AAMED FORCES? 1 YES 2 NO	13. WAS DECENDE	Suban, Maxican, Puart	GIN? (Specify Yea or No— o Rican, aic.)	14. RACE — American Indian, Black, White, alc.				
ЭВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 🗆 YES 2	NO Specify:		specify: Black				
ONCE.	15. DECEDENT'S EOUC. (Specify only highest grade of ElemegrapySegondery (0-12)	completed) (Give kind	NT'S USUAL OCCUPATION of work done during most of OT use retired.)	working	66. KIND OF BUSINESS/IN					
MPL	121	<u> </u>	erk Sup	enism	Social	Services				
E CC	17. FATHER'S NAME (First, Middle, Last)	lack	164	MOTHER'S NAME (First	, Middle, Melden Surname)	CICE				
TO BE CON	9a INFORMANT'S NAME (Type/Print)	C CK 23	194 Seam	umber or Rural Adite Nu	mber, City of Town, Stafe, 2					
	20 METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo	20b. PL CBAND D	ATE OF DISPOSITION (Name of	1 1. 01	TE 20c. LOCATION -	City or/Town, Stata				
	21. SIGNATURE OF FUNERAL SERVICE LICE	1 // 1371	100	PORESS OF FACILITY	High Hr	butus, Md				
хашш	Home !	A Thimasn -	mai	ch F. H	-west	1				
	23. PART I Enter the disease, or co	omplications that caused the death. D	Do not enter the mode of	of dying, such as ce	ordiec or reapiratory a					
ERTIFICATION	iMMEDIATE CAUSE (Finel disease or condition		con U	ENING	710	Interval Between Onset and Dasth				
, and a	IMMEDIATE PAUSE (Finel disease or gondition resulting in death) a. MENINGOCOCCAL MENINGITIS. DUE TO (OR AS A CONSEQUENCE OF):									
ION	Sequentially list conditions,	If any, leading to immediate								
CAT	csuse. Enter UNDERLYING CAUSE (Disease or Injury									
CERTIFICATION	that initieted events resulting in deeth) LAST	DUE TO (OR AS A CONSEQUENCE	E OF):							
AL CE	PART II. Other eignificent conditions	contributing to deeth but not resulting	ing in the underlying ce	use given in Pert I.	24s. WAS AN AUTOPSY					
					PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
2 2	DID TOBACCO USE C	ONTRIBUTE TO CAUSE O	OF DEATH YES	П ИО П		1 TYES 2 THO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQBPITAL:		OF DEATH (Check only	one)					
HYSICI/	1 YES 2 NO 27. MANNES OF DEATH	1 Inpatient 2 ER/Outpatient 3 DO. 28a. DATE OF INJURY 26b.	A 4 Nursing Home 5		her (Specify) ESCRIBE HOW INJURY O	CCURED				
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	M 1 YES							
reD I	3 Suicide 6 Could not be 4 Homicide detairmined	28a. PLACE OF INJURY — At home, far building, etc. (Specify)	rm, street, factory, offica	261. LC	OCATION (Street and Numb ity or Town, State)	er or Rural Route Number,				
COMPLET		IAN: To the best of my knowledge, death occ	curred at the lime, date and	place, and due to the o	cause(s) and menner ea st	lated.				
CON		: On the basis of examination end/or investig								
D BE COMPLETED BY PH	296. SIGNATURE AND TITLE OF CENTIFIER 296. SIGNATURE AND TITLE OF CENTIFIER	o MO		SZYY/Y/		ATE SIGNED (Month, Day, Year)				
10	M. MANEE AND ADDRESS OF PERSON WHO	YURI 300	Type, Print)			0,40 21225				
	DEC1 2 1994	32. REGISTRAR'S SIGNATURE								





FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

Shirley

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7. DATE OF BIRTH 1 - M 2 X-X 57 216-26-7210 July 6 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 4668 Pimlico Road Balto 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Md Balto FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 4668 Pimlico Road completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 21215 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 VINO 1 Never Merried 2 Merried Il yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 TES 2 X NO Specify: BY 3 X Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 12th Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) te. Walter Westley BE Nettie Ranson notified a 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Madeline Webster 3917 Dolfield Avenue Balto, Md pe 20e, METHOD OF DISPOSITION
1 (A Buriel 2, Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Western Star Cemetery 12129# Catonsville, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March F/H West JR moson me 4300 Wabash Avenue medical 23. PART I. Inter the diseees, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, ek, or heart fellure. List only one cause on each line. ö IMMEDIATE CAUSE (Final the cremation, disease or condition Gostric carinama resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) bunial, or other traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to the attending physician Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING the death certificate be CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST shows any Injury, PART II. Other eignificent conditione contributing to deeth but not reculting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL has been signed by Dept. of Health and 1 YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem certificate State HOSPITAL OTHER: 1 YES 2 NO 1 Inpatient 2 SER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 8 - Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with 1 28 is marked, 1 X Natural 1 YES 2 NO ВҰ death Investigation After 2 Accident OR ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suictde COMPLETED 8 Could not be determined DIRECTOR: after 4 Homfolde TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Item 2 29e. CERTIFIER 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner se stated. 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated, AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE (cove) Unuday Fellow D46331 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N- welfe St (Johns Haplain Hap) Oncelon Center. G. Scott Mena Bett. MD 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Powel1

6. AGE (In yrs. last birthday)

94 36653

YEAR

9c. COUNTY OF DEATH

1994

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: Black

1 X YES 2 NO

Approximate

Interval Between

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 - YES 2 1 NO

29d. DATE SIGNED (Month, Day, Year)

62/9/94

Onset and Death

4413 2man

8. BIRTHPLACE (State or Foreign

Md

10g, CITIZEN OF WHAT COUNTRY?

USA

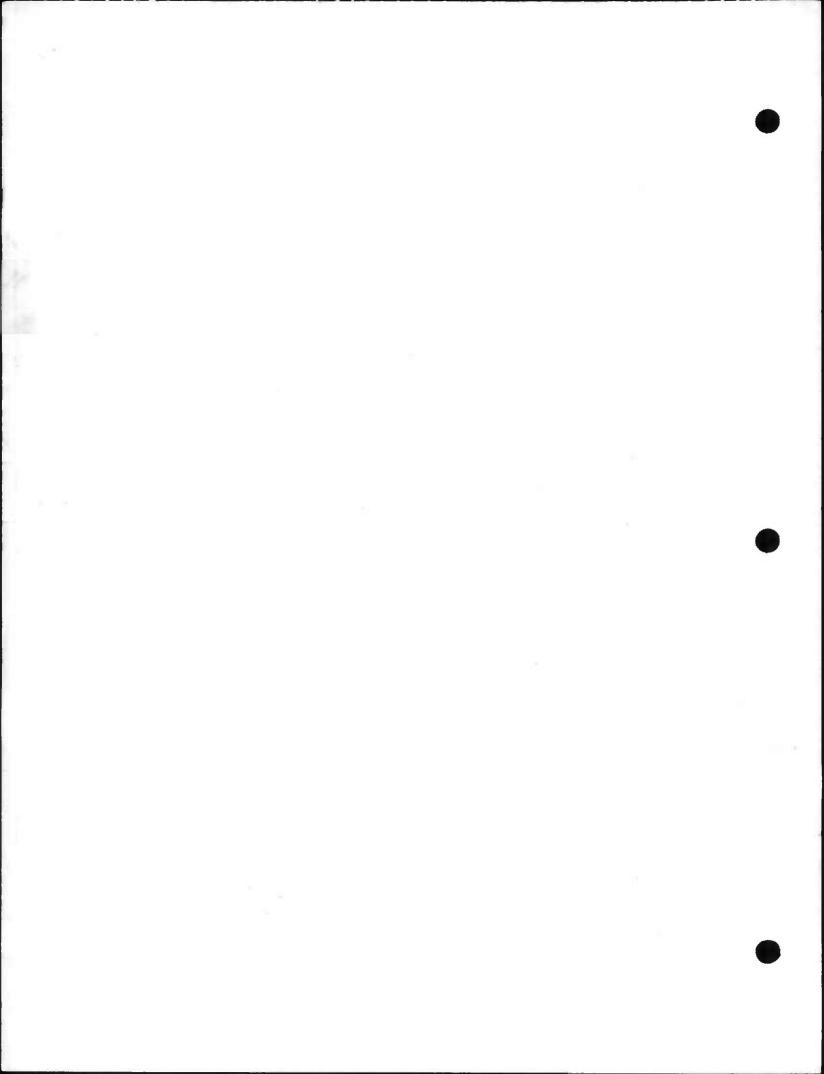
21215

REG. NO

2. DATE OF DEATH

Dec

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TETENDING PHYSICIAN: The law requires that the death certificate be executed writhin 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermin Pages 1.3 shows	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	if item 28 is marked or item 23 shows any injury, or other traumatic event the medical examinar must be notified at once
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	Ditto							14 3	0034
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND) / DEPAR Certifi	TMENT OF H	IEALTH AND DEATH		HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF MONTH		YEAR 3.	TIME OF DEATH
	DAVID BRIAN	POLLARD				NOV.			7:46A M
		5. SEX 6. AGE (In yrs. 1 M 2 F		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	8874 22125		GINJ.A
DIRECTOR	9a. FACILITY NAME (If not institution, give stre 910 MONTOR AVE				OL HEIGH			OUNTY OF DEAT RINCE G	
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY	, TOWN OR LOCAT	ION			1 10	d. tNSIDE CITY
	MARYLAND PRINCE	ITOL HG	TOL HGTS.						
FUNERAL	TILL MENTOR AVE.	12. WAS DECEDENT EVER IN U.S.		i	101. ZIP CODE 20743			U-S-A-	_
B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	If yes, sp	1 YES 2 YNO Specify: Sne				American Indian, hite, stc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	USUAL OCCUPATION ork done during more retired.)	ON st of working	16b. KI	ND OF BUSINESS/	INDUSTRY			
OMP	17. FATHER'S NAME (First, Middle, Last)		MECH	ANIC			UTO		
BE C	UNKNOWN RACHAEL POLLARD								
2	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) FELICIA POLLARD 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) FILI MENTOR AVE - CAPITOL HGTS - nMD - 20743								
	20s. METHOD OF DISPOSITION 1 N Burlel 2 Cremetton 3 Remov 4 Donetton 5 Other (Specify)	al from State 20b. PLAC	CEAND DATE O	F DISPOSITION (No	me of	DATE	20c. LOCATION		State
	21. SIGNATURE OF FUNERAL SERVICE LICES			22. NAME AN	D ADDRESS OF FA	ACILITY LE	WIS FUNE	ERAL HO	ME
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								
ERTIFICATION	Sequantisity list conditions, if any, lasding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL C	PART II. Other aignificant conditions	n the undarlying	g cause given in	Be given in Part i. 24a. WAS AN AL PERFORMI		AW CO	RE AUTOPSY FINDINGS IILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF D	EATH YES	S NO	UNCERTAI	\overline{N}		1 (YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		LACE OF DEATI	H (Check only one)					
YSI	TYES 2 NO	Inpatient 2 ER/Outpatient	3 DOA	4 - Nursing Hom	a 5 M Residence	8 Other (S	pecify)		
표	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	JRY WO	RK?	28d. DESCR	BE HOW INJURY		
B	2 Accident Investigation	1128 94	1740			Suns	V	401 56	
	3 Suicide a Could not be 4 Homicide determined	28a. PLACE OF INJURY — At building, etc. (Specify)		treet, factory, office		City or T	ON (Street and Number)		,
COMPLETE		AN: To the best of my knowledge,		d at the time, date	and place, and due				
8	one) 2 MEDICAL EXAMINER:	On the basis of examination and/	or investigation	ı, in my opinion, d	eath occured at the	time, data and	i place, and due to	the cause(s) an	d manner as stated.
BE	296) SIGNATURE AND TITLE OF CERTIFIER	all			O.C.M.			NOV. 2	orth, Day, Year) 9/94
10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (1			, BALTIM	MORE, M	IARYLAND	21201	
	DEC1 2 1994 July	38 REGISTRAR'S GNATURE	E	·					
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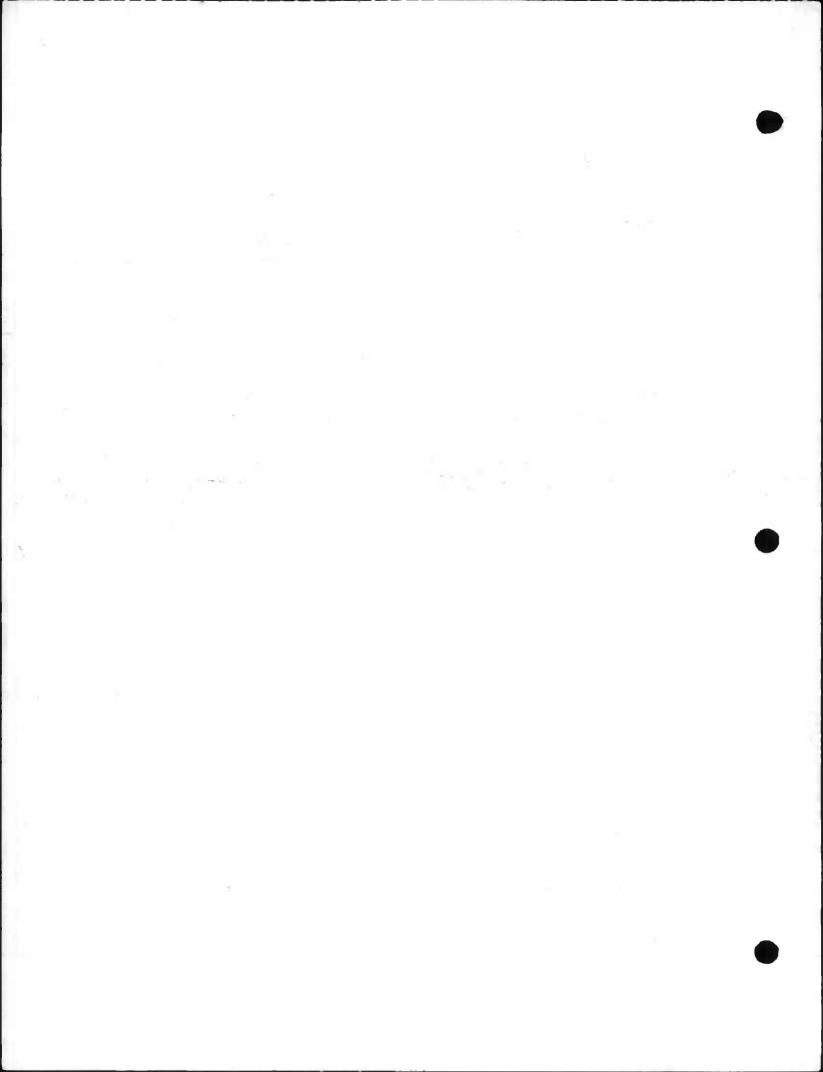
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	13			02,111	2. DATE OF DEATH		3. TIME OF DEATH		
	DORA		REICHL	YN				10:30 A. M		
		5. SEX 6. AGE (IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1994 8. Bif	THPLACE (State or Foreign			
- 3		1 🗆 M 2 🙀 F	70 YRS.	MONTHS DAYS	HOURS MIN.	MAY 11,1		MARYLAND		
	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOWN (R LOCATION OF DE		9c. COUNTY OF			
6	8509 CHURCH LANE			RAN	DALLSTON	VIN	BA BA	I.TIMORE		
E	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CITY	, TOWN OR LOCAT				10d, INSIDE CITY		
DIRECTOR	MARYLAND	MARYLAND BALTIMORE						LIMITS?		
	10e. STREET AND NUMBER			NDALLSTO	DWN	10g, CITIZEN O	1 YES 2 NO			
ER/	8509 CHURCH LANE				21133		USA			
FUNERAL		2. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF HISPAN	HC ORIGIN? (Specify Yes	or No.— 14, RA	CE — American Indian,		
BY F	1 Never Merried 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES			ecify Cuben, Maxica 2 NO Specify	n, Puerto Rican, etc.)		eck, White, etc.		
	Λ				73			WHITE		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	mpleted)	16a. DECEDENT'S (Give kind of w life. Do NOT us	ork done during mo	ON st of working	18b. KIND OF BUS	SINESS/INDUSTRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	1511/10/200							
OM	17. FATHER'S NAME (First, Middle, Last)		HC	DUSEWIFE		ME (First, Middle, Maiden	HOME			
	SAMUEL T	LEIBEN					Surriame)			
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	DOR nd Number or Rural F	A	n, State, Zip Code)			
٥	MRS. ARLENE MA	ANN	618	WELLER	DRIVE MT	AIRY, MD	21771			
	20e. METHOD OF DISPOSITION 1 Secretary 2 Comments 3 Remove	al from State	PLACE AND DATE	F DISPOSITION (Na	me of	DATE 20c. LOC	CATION — City or	Town, State		
	4 Donation 5 Other (Specify)	B	ETH EL M	EMORIAL	PARK - 1	2/8/94 F	RANDALLS	TOWN, MD		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE / ///	1	22. NAME AN	ID ADDRESS OF FA	CILITY	TNG			
	Scall !!	1. With	h			N & BROS.,		ORE, MD 2121		
	23. PART I. Enter the disesses, or con	nplications thet caused	the desth. Do n	ot enter the mo	de of dying, suci	h as cardisc or respin	ratory errest,	Approximate		
1	ehock, or heert fallure. Lis IMMEDIATE CAUSE (Final	it only one cause on e	ech line.					Interval Between Onset and Death		
	disease or condition resulting in death) a. Congestive Heart Failure DUEYD (OR AS A CONSPOURNE OF)									
	DUE TO (OR AS A CONSEQUENCE OF):									
NO	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	If any, leeding to immediate cause, Enter UNDERLYING	DUE TO (OH AS A	CONSEQUENCE OF):						
임	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):						
H	resulting in deeth) LAST							!		
	PART II Other eignificent conditions of	and-thuilen to death b								
MEDICAL	PART II. Other significent conditions contributing to deeth but not reculting in the underlying cause given in Pert I. Dialudes Mellitus, Chonic obstructive lung disease 1 yes 2 No									
ğ	piantes react	103, Chroni	C 015 100	ctime 1	ing disee	1 - YES 2	NO NO	DF DEATH?		
Σ	DID TORACCO LICE CONTROL	NITE TO CALLES O				_		1 TYES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIB		28. PLACE OF DEAT		UNCERTAIN	N X				
Sici		OSPITAL:		OTHER:	525-Residence					
Ŧ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME	OF 28c. INJ	JRY AT	28d. DESCRIBE HOW IN	JURY OCCURED			
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	ЛИП		RK? ES 2 NO			1		
	3 Suicide S Could not be	28e. PLACE OF INJURY building, etc. (Speci	— At home, term, s	treet, factory, office		281. LOCATION (Street a	nd Number or Rura	I Route Number,		
	4 Homicide determined					City or Town, State)				
7	29a. CERTIFIER (Check only) CERTIFYING PHYSICIA	N: To the best of my knowl	edge, death occurre	d at the time, date	and place, and due	to the ceuse(a) and man	ner sa stated,			
COMPLETED	2 MEDICAL EXAMINER:	On the basis of examination	and/or investigation	n, in my opinion, d	eath occured at the	time, data and place, end	d due to the ceuse	e(a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		0.4		29c. LICENSE NUM	IBER	29d. DATE SIGNI	ED (Month, Day, Year)		
TO B	Seter Floore	mp Atten	day Plu	ysicia	B50620	888€	12/	6/94		
F	30. NAME AND ADDRESS OF PERSON WHO C		7.77	,						
	Peter Sloane, mp		Ilvent 1	+ #65	· Balt	imore n	no 21	218		
	DEC1 2 1994 Jah	32 REGISTRAR'S BIN	Lall	1.3						
	DECT & 1334 Jun									





32 REGISTRAR'S ST

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should permit. Page 6 may be retained by the hospital or attending physician. Il director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 the funeral hours after death. the attending physician and completely filled in by Mental Hygiene prior to burial, cremation, or remo executed within signed by the certificate has been h the State Dept. of OR ATTENDING PHYSICIAN: this c After DIRECTOR: / FUNERAL within 72 h HOSPITAL

ITEMS: 23 PART I. 27. 28a-f. PER MEO FILM G-718 12/27/94 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE 1 -REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994 DEC. 04 1505 BENJAMIN ROBINSON 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5 SEY IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 8/3/1943 DAYS 190-32-6310 12 M 2 | F 51 YRS. Pittsburg, PA 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1-G G-3 Barn Room DIRECTOR pimlico Race Track baltimore RESIDENCE OF DECEDENT 10e STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore YES 2 NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1024 Bennett Place 21223 USA 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-If yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Merried 1 YES 2 NO Specify: BY Specify: 3 Widowed Divorced Black 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest ᇤ Elementary/Secondary (0-12) College (1-4 or 5+) Assistant to Trainer Pimlico Race Track 9th COMPL once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Willie Robinson Bessie ā BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sallie Williams 807 Painted Post Ct. Baltimore, MD 21208 pe 20a. METHOD OF DISPOSITION
1 □ Burlel 2 🗷 Cremetion 3 □ Removal from State
4 □ Donetion 1 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must Crematory 12/12 Catonsville, MD examiner 21. SIGNATUR OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE medical shock, or heart failure complications that caused he death. Do not anter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23. PARD Interval Batwean IMMEDIATE CAUSE (Final Onset and Death event, the disease or condition resulting in death) . NO ANATOMIC CAUSE OF DEATH DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated evants resulting in death) LAST 0 injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO Shows a 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item **EXAMINER?** HOSPITAL: OTHER XXYES 2 | NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK?

1 YES 2XX NO 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Natural 5 Pending P M 12-4-94 FOUND LINKNOWN ВУ 2 Accident Investigation 28s. PLACE OF INJURY — At home, ferm, building, etc. (Specify) 3 Sulcide 28 is 8 XXCould not be determined 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide UNKNOWN UNKNOWN Item 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(e) end menner as stated. = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I' 2 UMEDICAL EXAMINER: On the basis of magnination end/or investigation, in my opinion, death occured at the time, data end place, and due to the cause(e) and menner se stated. 28. SEMATURE AND TITLE OF CERTIFIE O.C.M.E. DEC. 05, 1994 BE 9 NAME AND AGORESS OF WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PERSON 111 Penn Street, Baltimore, Maryland 21201

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

Ι	tem # 1.19 Film # G 71	8 12-12-94	N.A. Per Fur	neral Home			94	36651		
>	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND / DEPAR CERTIF	RTMENT OF H	IEALTH AND	MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	+ V.	ROB		2. DATE OF DEATH	1°994 ''	3. TIME OF DEATH 2:50 pm M			
	4. SOCIAL SECURITY NUMBER 2/8-80-45/0 98. FACILITY NAME (If not institution, give si	5. SEX 1 M 2 X XF	6. AGE (In yrs. last birthday) 97 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1897	BIRTHPLACE (State or Foreign Country) ManyLand		
TOR	Saint Joseph Medical Center Residence of Decement Saint Joseph Wedical Center Residence of Decement Section of Death									
DIRECTOR	10a. STATE 10b. COUNTY			ITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 □ NO						
FUNERAL	6116 Belain Rd				2/236		4.5			
ΒY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	NT EVER IN U.S. ARMED I YES 2 NO MAR OR DATES	ecify Cuben, Mexico 2 NO Specifi	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) fy	or No.— 14.	RACE — American Indian, Black, Whita, atc. Specify: White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refined.) HOULEWILE Home									
ш	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surmame) John Jacob Schmidt Mary L. Wheat									
TO B	190. INFORMANT'S NAME Ethel A. Ethel A. Imbra	. Imbragug.	196. MAILING 5/7			Route Number, City or Tow Balto., Md				
	20a. METHOD OF DISPOSITION Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		20b. PLACE AND DATE cemetery, cremetory or o	ther place)		12/12 Ba		or Town, Stata		
	Coay D. J	muth.		Hart. 7527	ND ADDRESS OF FA Ley Mil Harlon	Ler Fune	ral H	ome Md. 21234		
	23. PART I Finance of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of):									
ERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST									
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE ARTERIOSCLEROTIC CARDIVASCULAR DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YOU	HOSPITAL:	26, PLACE OF DEA	TH (Check only one) OTHER:		8 Other (Specify)				
ву РНУ	27. MANNER OF DEATH Natural 5 Pending Investigation	28a. DATE OF (Month, D	lay, Year) INJ	M 1 .	PK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCUR	ED		
- 0	3 Suicide 6 Could not be detarmined	building,	PF INJURY — A1 home, 1erm, a stc. (Specify)			281. LOCATION (Street & City or Town, State)		Rural Route Number,		
COMPLETED	one) 2 MEDICAL EXAMINE	Ri Op the basis of a	I my knowledge, death occurre xamination and/or investigation		eath occured at the	time, date and placa, an	d dua to the ca	nuse(a) and manner as stated.		
296. SIGNATURE AND TITLE OF CETTIFIC (Mong Day War)							1919 (Monty Day, War)			

investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and m 296. SIGNATURE AND TITLE O D08344 AND JODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) SAINT JOSEPH MEDICAL CENTER 7620 YORK ROAD TOWSON, MARYLAND

32. REGISTRAR'S SIGNATURE

Section 2. 1 section of the section

Dr. Robert Dart

31. DATE FILED (MONTH, Day, Year)
DEC1 2 1994

			1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.										
			1. DECEDENT'S NAME (First, Middle,	Last)					2, DAT	E OF DEATH		YEAR	3. TIME OF DEATH
	- 1			Paul F		rtoris	3			ember	-	994	0858
			4. SOCIAL SECURITY NUMBER	5. SEX 8. A	GE (In yrs. las	- 12 M	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mo	E OF BIRTH nth, Day, Year)		6. BIRTH Countr	IPLACE (State or Foreign y)
pinc		ı	199 16 7604 9a. FACILITY NAME (If not institution,	32	70	YRS.	L OITH TOWN	2010017101107		31, 1	_		nsylvania
, 2, 3 should		ECTOR									EATH		
iges 1		35		OUNTY		10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE CITY
. <u>≒</u>		DIR.	Maryland .	Anne Arundel		Lir	thicum				LIMITS?		
per		FUNERAL	10e. STREET AND NUMBER				101. ZIP CODE						WHAT COUNTRY?
an. transit		NE I	635 Gayle Drive 21090							U.S.A.			
21215-0020 If or attending physician. for use as the burial-transit permit. Pages 1,		BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 _ Y IF YES, GIVE WAR OF	ES 2 🔀	MED 10	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) t ☐ YES 2 ☑ NO Specify:					14. RACE — American Indian, Black, Whita, etc. Specify: White	
215- intendi			16. DECEDENT'S	S EDUCATION	16a. DE	CEDENT'S US	UAL OCCUPATI	ON	10	6b. KIND OF BUS	SINESS/INC	USTRY	wiite
21 al or for u		COMPLET	(Specify only highest Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	life	Do NOT use		ost of working		Brewi	ng Co	o. –	Beer
AN he ho	once.	Š	17. FATHER'S NAME (First, Middle, Las	st)				16. MOTHER'S N	AME (First				
YK d by t	76	BEC		John Sart	oris			Ma	deli	ine Ze	none		
S 5 ℃	notified	2	Sophia D. Sa.	•			odress (Street	ond Number or Rural		mber, City or Tow			1090
M > @	must be		20e. METHOD OF DISPOSITION 1 Striel 2 Cremetion 3 Clare (Specify)	Ramoval from State	20b. PLACE : cemetery, cre Mead	MD DATE OF matory or othe DWY1CO	DISPOSITION (No. 1) Plece) e Memo:	rial Par	k12/	13 Ba	cation -		wn, State Maryland
BALTIMOR er death. Page 6 ma the funeral director, p	examiner		21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A.									Α.	
B after of the			4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
100 PG	Ē		shock, Dr haart failure. List pniy ona cause on each line. IMMEDIATE CAUSE (Final							out,	intarval Between		
25 章 5	event, the		disease or condition resulting in death)	• Ventric	ular	Arrhy	-bmia						minutes
68760, accuted within	even	1	,	a. <u>Ventric</u> DUE TO (OR A									
68 Bud Gecu	natic	S I	Sequentially list conditions, Arteriosclerotic Coronary Artery Disease Due to (or as a consequence of):									3 years	
Cian be	traumatic	CERTIFICATION	If any, leading to Immediate cause. Entar UNDERLYING ANGER OF THE CONTROL OF THE									3 years	
	other	띮	that initiated events DUE TO (OR AS A CONSEQUENCE OF):										Jacars
0 - 5 -	0 0	ERT	resulting In death) LAST	d									
00 00	200	111	PART II. Other significant cond	ditions contributing to deat	h but not r	asulting in	tha underlyin	g cause given in	n Part I.	24s, WAS AN	AUTOPSY	246	WERE AUTOPSY FINDINGS
四日日	i >-	EDICAL								PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
m 9 9 5	2	Σ	DID TORACCO LISE CO	NITRIBLITE TO CALICE	OF DEA	TII VCC		1 UNICEDIAL					1 TYES 2 NO
	1 23	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
	Item	SIC	EXAMINER? 1 ☐ YES 2 🏋 NO	THER:									
OF V PHYSICIA this certification		ੇ ∥	27. MANNER OF DEATH	1 Inpatient 2 XER/O	ry	28b. TIME (OF 28c. IN.	IURY AT	1	ESCRIBE HOW II	NJURY OCC	CURED	
N O O O O O O O O O O O O O O O O O O O		BY P	1 X Natural 5 Pending 2 Accident Investigs		(Month, Day, Year) INJURY WORK?			ORK? YES 2 NO					
DIVISION OF VI OR ATTENDING PHYSICIAN: DIRECTOR: After this certifical	28 Is	ETED B	3 Suicide 8 Could not be determined 26s. PLACE OF INJURY — At home, term, street, building, stc. (Specify)					eet, factory, offica 281. LOCATION (Street and Number or Rural Route Numb City or Fown, State)					loute Number,
S S S S S S S S S S S S S S S S S S S	Item	MPLE	29a. CERTIFIER 1 CERTIFYING	PHYSICIAN: To the beat of my kn	owledge, de	ath occurred	at the time, date	and place, and du	e to the c	ause(s) and man	mer as atat	ed.	
SPITAL FRAL		N N		AMINER: On the besis of examina) and manner as stated.
\$ P. S	E	3	29b. SIGNATURE AND TITLE OF CER	TIFIER				29c. LICENSE NU	IMBER		29d, DATI	E SIGNED	(Month, Day, Year)
E E S	- M	7	Konseit Daw	F 71.				1739U	دلون)	► \7	-	194
-	_	F	30. NAME AND ADDRESS OF PERSO	N WHO COMPLETED CAUSE OF	DEATH (ITE	1 27) (Type, Pr	int)						

707 E. Fort Avenue

Baltimore, Maryland 21230

DWG ITEMS: 23 PART I, 27, PER MED FILM G-Item#1 Per F.H. Film# G-718 /12/17 /12/ 7/94 94 I, 27, PER MED FILM G-718 12/17/94 t.t H. Film# G-718 12/12/94 R.M. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR			CATE OF DE		REG. N						
1. DECEDENT'S NAME (First, Middle, Lent)					2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH			
DELORES SOYE						28	94	7:35P			
4. SOCIAL SECURITY NUMBER 218 42 4249	State of the company of the contract of		FUNDER 1 YEAR IF S HONTINE DAYS HOS	MOEN 24 HMS.	7. DATE OF BIRTH (Month, Day, War) 7/30/43	Ĭ	Count	#PLACE (State or Foreign (Y))			
9a. FACILITY NAME (If not institution, give in 1532 ARGYLE in 1532 ARGYLE in 1532 ARGYLE in 164 ARGYLE in 164 ARGYLE in 165 ARGY			BALTIMORE CITY				Be. COUNTY OF DEATH				
RESIDENCE OF DECEDENT											
	0.0000000000000000000000000000000000000	ALTIMORE				10d. INSIDE CITY LIMITST 1 (2) YES 2 NO					
1532 ARGYLI	E AVE.	=======================================	101. ZIP CODE 21217			10g. Cf	USA.	USA.			
15.3.2 ARGYLI 1. MARITAL STATUS 1. Never Married 2 Married 2 Widowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES 2				NIC ORIGIN? (Specify in, Puerto Ricen, etc.)	Specify:					
15. DECEDENT'S EDU	CATION	16a. DECEDENT'S U	SUAL OCCUPATION	166. KIND OF 8	AFR. AME						
(Specify only highest grade Elementary/Secondary (0-12) 1.2	College (1-4 or 5 +)	(Give kind of work dane during roost of working life. On NOT use restreed.) MAIL CLERK			FORT MEADE						
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)											
WILLIE A.	SAWYER			FRAN		WYER					
19a. INFORMANT'S NAME (TypePrint)		19b. MAILING A	DORESS (Street and Mu	mber or Rural	Route Mumber, City or T	wn, State Z	(p Code)				
ASCIA SAWYER	3		ARGYLE AVE								
20s. METHOD OF DISPOSITION	296. METHOD OF DISPOSITION DATE 266. LOCATION — City or Timen.										
1 Donation □ Other (Special)	//	TAICS PARK	wmartery or other place)								
21. BARRATURE OF FUNERAL SERVICE LICENSIAN MD. 22. NAME AND ADDRESS OF FACILITY											
ESTEP BROTHERS FUNERAL HOME P.A.											
disease or condition resulting in death)	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SARCOIDOSIS OUE TO (OR AS A CONSEQUENCE OF):										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	If any, leading to immediate cause, Enter UNDERLYING										
that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PRIFORMED? ANA											
1 (SYES 2 NO											
DID TOBACCO USE CONT	RIBUTE TO CAUSE O			NCERTAIN	V 🗆						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 (2) YES 2 (1) NO	HOSPITAL:		(Check only one) OTHER: Nursing Home 1	□ Other (Specify)							
27. MANNER OF DEATH V()) Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Deg. War)	28h. TIME (284. DESCRIBE HOW INJURY OCCURED						
3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre	At home, term, street, factory, office			281, LOCATION (Street and Number or Flurel Route Number, City or Toers, State)					
	CIAN: To the best of my know) and manner as alot-4			
296. SIGNATURE AND TITLE OF CERTIFIES											
Machine 120		29c. LICENSE NUI O . C . M .			E. NOV.						
MDMPROD D	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P. 11 Penn	Street,	Balt	imore,	Mary	land	21201			
DECT 2 1994	31 REGISTRACTIONAN	Martically									

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law impulies that the death certificate be esecuted within the flours whe death. Page 6 may be intained by the hospital or attending physician and completely fleed in by the tuneral director, page 5 should be detached for use as the burish-transit be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiens prior to burist, cremation, or remotal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

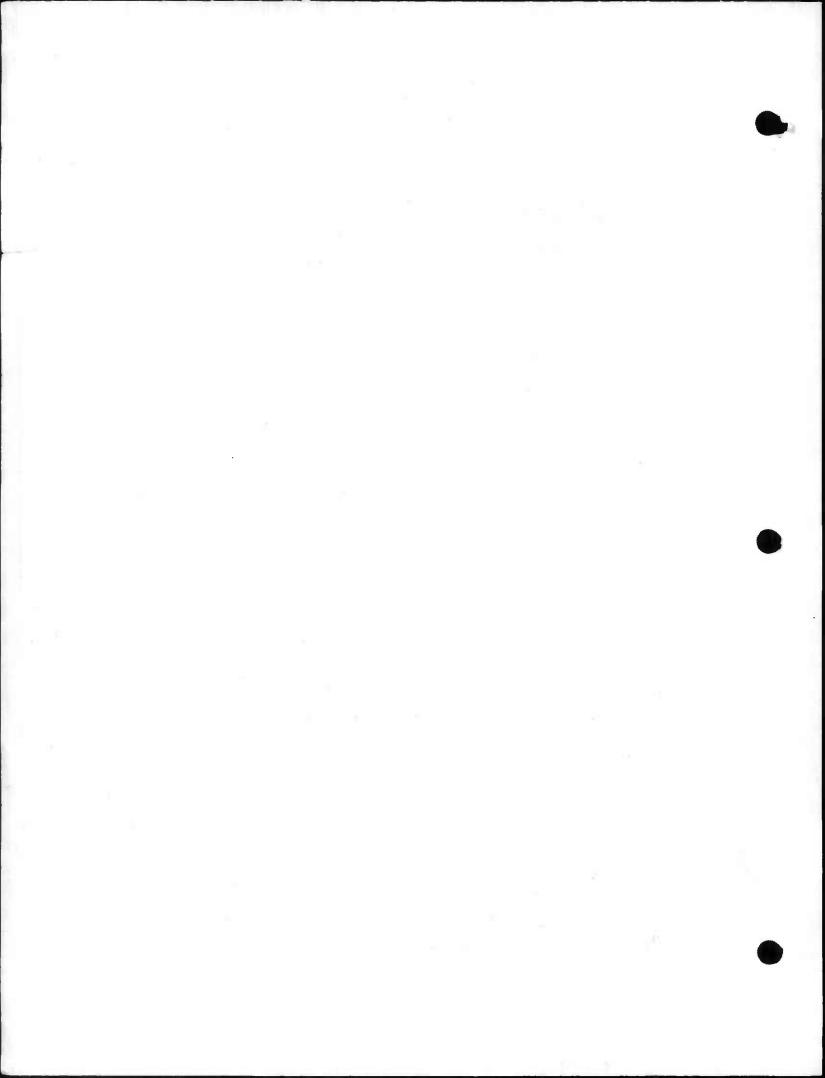
permit. Pages 1, 2, 3 should

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hydlene prior to burial, cremation or removal	aš
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DR	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filled within 72 hours after death with the State Degr. of Health and Mental Hynlene enfor to build, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAI	HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)				OF DEATH	3. TIME OF OEATH						
	DAVID		CRUGGS	DECE	MBER 6	1 0610 M						
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BURTH	6.1	BIRTHPLACE (State or Foreign			
_	374-38-2027	1½ M 2 □ F	55 YRS.	MONTHS DAYS	HOURS MIN.		, Day, Year) - 3 9		Country) LABAMA			
	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF			9c. COUNTY				
DIRECTOR	KIMBROUGH ARMY COMMUNITY HOSPITAL FORT MEADE ANNE ARUNI											
S S	10e. STATE 10b. COUNT	Y	10c CIT	r, TOWN OR LOCA	TION				Last many one			
E C	MD								10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER		B		LTIMORE CITY			10a CITIZEN	1 YES 2 NO			
FUNERAL	5207 PETTEVILL						- 4	USA				
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13 WAS DECEMBENT OF HISPANIC ORIGINA (Specific Version No. 14 PAGE							RACE American Indian.				
BY F	1 Never Merried 2 Merried	FORCES? 1 YES	FORCES? 1 YES 2 NO If yes, specify Cuben, Mexice IF YES, GIVE WARD OR DATES 1 YES 2 NO Specify									
	3 Widowed 4 Divorced	1959-AUG.		A			BLACK					
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of v	USUAL OCCUPATION done during me retired.)	ON ost of working	16b.	KIND OF BUS	INESS/INDUST	RY			
4	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)								
M	IINKNOWN 17. FATHER'S NAME (First, Middle, Lest)	HNKNOWN	WAREHO	USE WO		1.5						
					18. MOTHER'S N			Sumame)				
B	10HN PETERSON 19e. INFORMANT'S NAME (Type/Print)	Į.	Professions		MARY							
2			5207		and Number or Rura	AVE.		O. MD				
	DORA SCRUGGS 200. METHOD OF DISPOSITION	200										
	1 N Burlel 2 Cremetion 3 Removal from State											
	21. SIGNATURE OF PUNERAL SERVICE LICENSEE WOODLAWN CEM. 12-12 WOODLAWN DRIVE 22. NAME AND ADDRESS OF FACILITY											
	Much arroll 1. CARROLL F7H 1712 WEST NORTH AVE.											
	23. PART i. Enter the diseeses, or o	complications that caused	the deeth. Do n	ot enter the me	de of dying, au	ich as card	lac or respir	atory arrest.	Approximate			
	ahock, or heert fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel											
1	disease or condition DIABETES MELLITUS											
	DUE TO (OR AS A CONSEQUENCE OF):											
Z	RENAL FAILURE											
Ĕ	Sequentially list conditione, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
2	CAUSE (Disease or injury	c. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF):										
Ē	thet initiated events resulting in death) LAST	DUE TO (OH AS A	CONSEQUENCE OF):								
CERTIFICATION	d											
AL	PART II. Other significant condition	e contributing to death b	ut not resulting i	n the underlyin	g ceuse given i	n Pert i.	24e. WAS AN A	UTOPSY	24b. WERE AUTOPSY FINDINGS			
2						- 1	PERFORM		AMAILABLE PRIOR TO COMPLETION OF CAUSE			
								X	OF DEATH?			
ż												
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. P	ACE OF DEATH (C	Check only one)					
Sic	1 TES 2 XNO	HOSPITAL: 1 Inpatient 2 ER/Outp	atlent 3 🗆 MOA	OTHER: 4 Nursing Hon	e 5 🗆 Residence	8 🗆 Other	(Specify)					
F	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI		URY AT	26d. DEŞ	CRIBE HOW IN	JURY OCCURE	:0			
BY	1 2 Netural 5 Pending 2 Accident Investigation				YES 2 NO	NO						
COMPLETED	3 Suicide 8 Could not be determined City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural City or Town, State)							lurel Route Number,				
	29e. CERTIFIER					1						
MP	(Check only	CIAN: To the best of my knowl	edge, death occurre	d at the time, date	end place, end du	e to the caus	e(e) end menr	ner ee stated.				
8	one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated.											
B	296. SIGNATURE AND TITLE OF CERTIFIER	1. 1	1		29c. LICENSE NO	UMBER		29d. DATE SIG	GNED (Month, Day, Year)			
2	prum	The same of the sa	1		D46488			DEC	EMBER 6, 1994			
	JACQUELYN M. ISL				NATO	2075	E E000					
20733 3000												
	DEC1 2 1994	32. BEGISTRAR'S SUN	Jaly									
	4											

Ward would be to the first the

	FOR 1 - STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTM			MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)	ELTMAN				2. DATE OF DEATH MONTH	DAY	YEAR 9 V	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5.				IF UNDER 24 HRS. HOURS MIN.	MIN (Month, Day, Year)			a. BIRTHPLACE (State or Foreign Country) North Carolina		
DIRECTOR	120-05-5650 1 May 8, 1908 Nort 90. FACILITY NAME (If not institution, give street end number) Frederick Memorial Hospital Frederick Frederick Frederick							ITY OF DE	ATH		
	RESIDENCE OF DECEDENT	RESIDENCE OF DECEDENT									
DIRE	Maryland Anne Arundel Glen Burnie								10d. INSIDE CITY LIMITS? 1 YES 2 NO		
COMPLETED BY FUNERAL	100. STREET AND NUMBER 801 Marigold Rd. 1007. ZIP CODE 1009. CITIZEN CO United								HAT COUNTRY?		
		2. WAS DECEDENT EVER IN U.S FORCES? 1 1 YES 2 IF YES, GIVE WAR OR DATES	AS DECEDENT EVER IN U.S. ARMED DRCES? 1 Yes 2 NO 13. WAS DECENDENT OF HISPA			NIC ORIGIN? (Specify Yes or No.— 14 can, Puerto Rican, atc.)			14. RACE — American Indian, Black, White, etc. Specify: White		
	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) 1 2	mpleted) College (1-4 or 5+)	or 5+) 160. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			166. KIND OF E					
WOS	17. FATHER'S NAME (First, Middle, Last) James Bass				ME (First, Middle, Maid						
띪	190. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street e.		Hulda Co					
2	Joseph L. Gault		19b. MAILING ADDRESS (Street end Number or Aural Acute Number, City or Town, State, Zip Code) 801 Marigold Rd., Glen Burnie, Maryland 2								
	20e. METHOD OF DISPOSITION 1 Burlet 2 Correction 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetary, or other place) Method Correction 5 Other (Specify) Method Correction 1 Do 04 Catons ville Many lan										
22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funera							1 Home				
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heert failure. List only one cause on each line. Approximate interval Between										
									Onset and Death		
N	Sequentially list conditions, b										
CATIC	tif any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CON	DUE TO (OR AS A CONSEQUENCE OF):								
A	PART II. Other significent conditions of	ontributing to deeth but n	ot resulting in th	e underlying	ceuse given in	Part I. 24a. WAS / PERF	N AUTOPSY ORMED?	100	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
PHYSICIAN: MEDIC	1 □ YES 2 MNO OF								COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
AN:	DID TOBACCO USE CO	ONTRIBUTE TO C	AUSE OF D						book		
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO										
	27. MANNER OF DEATH 1. Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK?			RK?	28d. DEŞCRIBE HOW INJURY OCCURED					
TED BY	2 Accident Investigation 3 Suicide 6 Could not be distermined Stermined Stermined M 1 YES 2 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED		N: To the best of my knowledge							7		
	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER.										
TO BE	W. Magain M. D. 12/9/94										
	30. NAME AND ADDRESS OF PERSON WHO	LIGHTEN		INTW	ick	MD 2	1716				
	DECT 2 1994 July	32 REGISTRAR'S CONATULE	Ù,								



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

BALTIMORE, MARYLAND 21215-0020 ours after death. Page 6 may be executed with death certificate be

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Murrel 1 Ellsworth Smith December 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 1 X M 2 - F 83 215-403-6969 JAN. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Greater Baltimore Medical Center Towson 10b. COUNTY 10c, CITY, TOWN OR LOCATION Maryland **Baltimore** FUNERAL 10f ZIP CODE use as the bunal-transit 201 Taplow Rd 21212 retained by the hospital or attending physician. 5 should be detached for use as the bunal-tran 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, atc.) FORCES? 1 YES 2 NO 1 Never Merried 2 Merried 1 TES 2 NO Specify: BY 3 X Widowed 4 Divorced WW II COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION Elementary/Secondery (0-12) College (1-4 or 5+) Vice President 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) F James E. Smith Emma BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Murrell E. Smith, Jr. page 5 s 500 Somerset Rd. Baltimore, Md. 9 20e. METHOD OF DISPOSITION
1 □ Burlel 2 □ Cremetion 3 □ 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 | Burlel 2 | Cremation 3 | Removat from State
4 | Donation 5 | Other (Specify) | Entomoment funeral director, Dulaney Valley Mausoleum 12/12 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY James 7. Beuneide, Mitchell-Wiedefeld Home, Inc. filled in by the fion, or removal. 6500 York Rd. Baltimore, Md medical 23. PART. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** cremation, event, the diseese or condition **SEPSIS** completely resulting in deeth) OUE TO (OR AS A CONSEQUENCE OF): and com PNEUMONIA traumatic CERTIFICATION Sequentially list conditiona, ung physician a OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CVA CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST attending 0 n signed by the attend f Health and Mental H Inlun. PART II, Other algnificent conditione contributing to deeth but not resulting in the underlying ceuse given in Part I. requires that the MEDICAL any PLEURAL EFFUSIONS Shows **QUADRIPARESIS** t. of } DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X PHYSICIAN: s certificate has ber th the State Dept. AND. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL OR ATTENDING PHYSICIAN: The Hem OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED this c marked. Netural

Accident 5 Pending Investigation 1 YES 2 NO DIRECTOR: After to BY 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 60 3 Sutcide COMPLETED 8 Could not be 28 4 Nomicide tem 29e. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner ee atsted. FUNERAL within 72 h = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 13 2 MEDICAL EXAMINER: On the investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) end manner es stated. 29b. SIGNATURE AND 29c. LICENSE NUMBER 띪 D34988 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. 650: David G. Roberts Charles St

94 36662

YEAR

9c. COUNTY OF DEATN

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

USA

Specify:

Chesapeake Paperboard Co.

21210

Cockeysville, Maryland

Baltimore, Md.

Approximate Interval Between

Onset and Death

AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 NO

OF DEATH?

month

Month

20c. LOCATION — City or Town, State

1994

3. TIME OF DEATH

5:15a

IOd. INSIDE CITY

1 X YES 2 NO

White

8. BIRTHPLACE (State or Foreign

Maryland

14. RACE — American Indian, Black, White, etc.

REG NO

24

9

16b. KIND OF BUSINESS/INDUSTRY

24a. WAS AN AUTOPSY PERFORMED?

1 TES 2 NO

21204

Raltimore .Md

DATE

2. DATE OF DEATH

281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) ▶ 12-9-94 DHMH-18 Rev 1/89 The state of the s

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296. SIGNATURE AND TITLE OF CERTIFIER

· mu

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

July Deutser hardell

UN

funeral director, page 5 should

DIVISION OF VITAL RECORDS, P.C

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W. The law n	ficate has be	State Dept.	. Item 23 s
CAN: The law n	entificate has be	the State Dept.	or them 23 s
SICIAN: The law r	dentificate has be	fige State Dept.	of or Item 23 s
PRESIDIAN: The law n	he derifficate has be	An the State Dept.	had or them 23 s
PHYSICIAN: The law n	CTHE CONTRICATE has be	The State Dept.	arried or thim 23 s
NG PHYSICIAN: The law r	A The dertificate has be	Last With the State Dept.	married or Item 23 s
CALLE PRESIDAN: The law r	A A The dertificate has be	- Authorn the State Dept.	is married or item 23 s
TEACHE PROSICIAN: The law r	R. Apr., this dentificate has be	her shalf with the State Dept.	Is married or Item 23 s
UTE ONE PRESCRAY. The law r	COPP. Ask, this dentificate has be	. ther was with the State Dept.	2 Is married or Item 23 s
R ATTENDITE PRESIDAN: The law r	RECTAR AND THE GENTHCARE has be	urs ther war with the State Dept.	in 21 is marked or item 23 s
OR ATTERMINE PRESIDENT THE law of	DIRECTAL AND THE CAMPICATE has be	hours ther wat with the State Dept.	Item 21 is marked or Item 23 s
AL OR ATTERMIG PROSICIAN: The law r	AL DIRECTOR: Any this defificate has be	2 hours ther day with the State Dept.	If Item 2, is marked or Item 23 s
PITAL OR ATTERMINE PRESIDAN: The law n	ERAL DIRECTOR: Apr. This demiticate has be	n 72 hours ther was with the State Dept.	T-If Item 21, is marked or Item 23 s
DSPITAL OF ATTENDING PRESIDIAN. The law r.	INERAL DIRECTOR AND THE CONTRICATE has be	thin 72 hours ther way with the State Dept.	NT-If Item 2, is marked or Item 23 s
HOSPITAL OR ATTENDING PRESIDENT THE IZW F	FUNERAL DIRECTOR AND THE CONTRICATE has be	within 72 hours there was with the State Dept.	TANT: If Item 2, is marked or Item 23 s
HE HOSPITAL OR ATTERMINE PRESIDAN: The law n	HE FUNERAL DIRECTOR AND THE CONTINCATE Was be	ed within 72 hours ther way with the State Dept.	DRTANT: If Item 2. Is marked or Item 23 s
THE HOSPITAL OF ATTERMINE PRESIDAN: The law n	THE FUNERAL DIRECTOR AND THE CONTRICATO has be	filed within 72 hours then was him the State Dept.	PORTANT-If Item 21, is married or Item 23 s
TO THE HOSPITAL OR ATTENDIB PRESIDAN. The law requires that the death certificate be executed with.	TO THE FUNERAL CHEETING COMPLETING CONTINUES DEEN SIGNED by the attending physician and completely filled in by the 1	be filed within 72 hours me see that the Share Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 21, is married or item 23 shows any injury, or other traumatic event, the medical ex

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR Snide CERTIFICATE OF DEATH John 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 1994 John Snider Dec. 10 11:44 P.M Robert 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 509-34-5317 58 1 XM 2 F YRS. Oklahoma Dec. 15, 1935 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH DIRECTOR 5157 Evangeline Way Columbia Howard 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard Columbia 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 5157 Evangeline Way 21044 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 ☐ YES 2 ☆ NO Specify: Specify: В 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Dept. Of Defense Elementary/Secondary (0-12) College (1-4 or 5+) Personnel Manager 5+ U.S. Government 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) William Snider Velma E. McCullough BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5157 Evangeline Way Columbia Maryland 21044 Kelmie A. Snider (Spouse) 20e. METHOD OF DISPOSITION

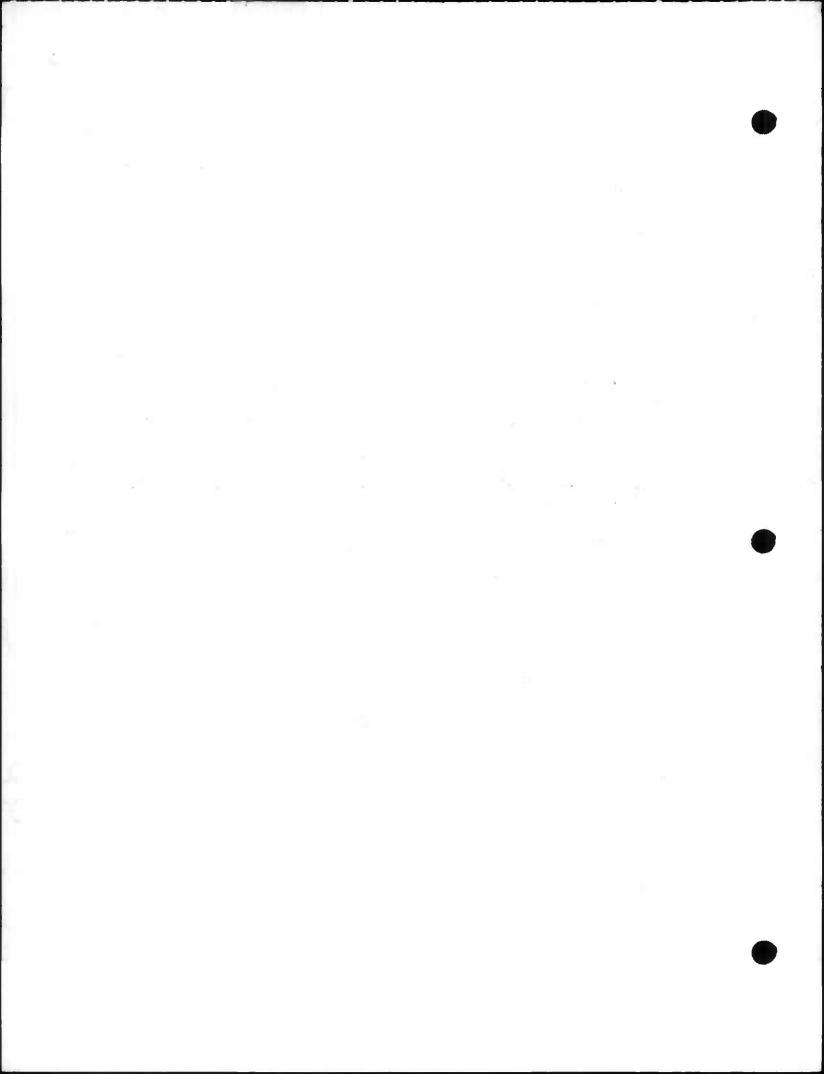
1 Durist 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Number of 2/13/94 DATE cemetery, cremetory or other place)
Christ Episcopal Church Cemetery 20c. LOCATION — City or Town, State Columbia, Maryland 21. SIGNATURE OF FUNERAL SERVICE LIN 22. NAME AND ADDRESS OF FACILITY Умания Leroy M & Russell C Witzke Funeral Homes 1630 Fdmondson Avenue Catonsville Maryland 23. PART i. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate shock, or heert feliure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Fine) **Onset and Death** disease or condition Responstery Failure resulting in death) OUE TO (OR AS A CONSEQUENCE OF): edfina). Ald Asserve a II geoff gove Adenolarinona of 1 CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): thei initieled events resulting in deeth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? COPD. Christi animin, 1 TES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES YNO UNCERTAIN PHYSICIAN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) 1 YES 2 NO OTHER: 4 Nursing Home 5 Neeldenca 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 2 Acciden 5 Pending М 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stelle) 6 Could not be COMPLETED 4 Homicide determined 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

D30573

29d. DATE SIGNEO (Month, Day, Year)

12-11-94



36664 94

FOR

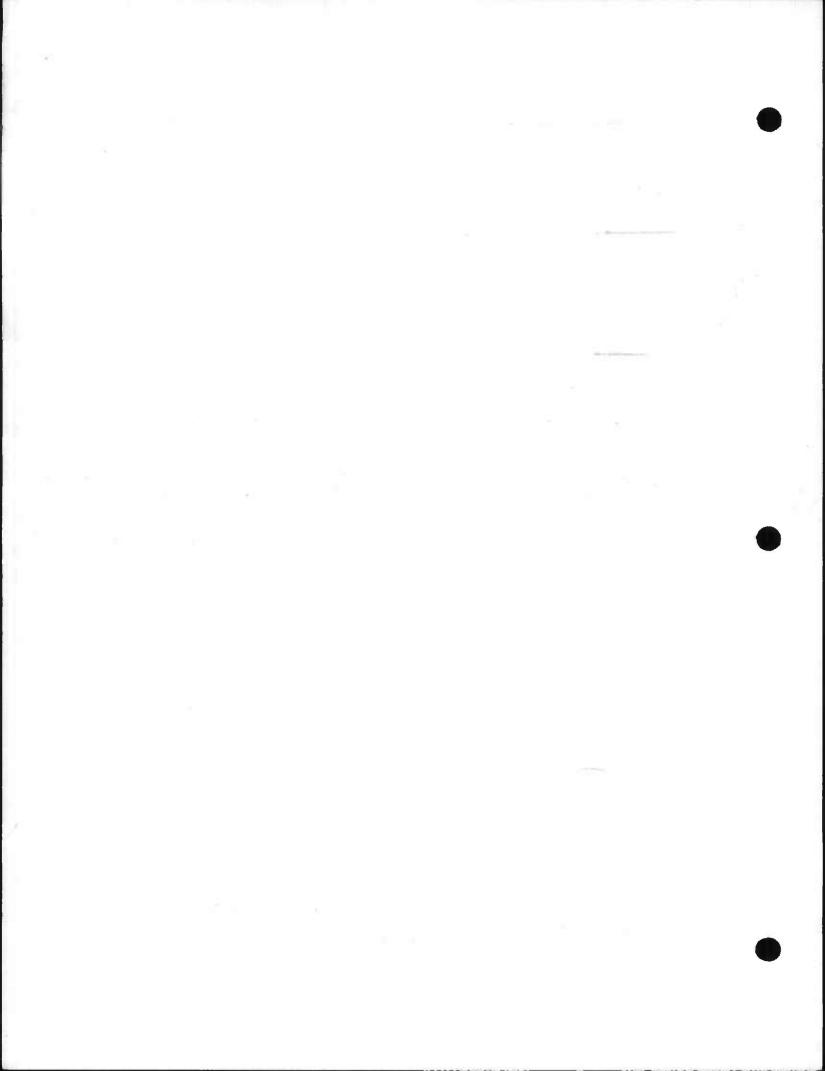
	1 - STATE REGISTRAR	CI		ICATE C				EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH MONTH AVERAGE 3. TIME OF DEATH										
										9 ^{YEAR}	7:25P M
	4. SOCIAL SECURITY NUMBER 5. SEX	MONTHS DAYS HOUSE						BIRTH ly, Year)		8. BIRTH Countr	PLACE (State or Foreign y)
	213 10 0113	1 □ M 2 X F 36 YRS.)/195	_		ryland
æ	9a. FACILITY NAME (If not institution, give street and number				N OR LOCATIO			i	9c. COU	NTY OF D	EATH
DIRECTOR	JOHNS HOPKINS HOSI	BAY V	LEW	BALT	IMORE	CIT	I. A				
HE I	10a. STATE Nary Land 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY LIMITS?
	Mar land B	altimore				Dur	ndalk				T YES 2 NO
Ž.	10e. STREET AND NUMBER				10f. ZIP COOE						YHAT COUNTRY?
E I	6711 Oak Avenue					212				ited	States
COMPLETED BY FUNERAL	19 Never Merried 2 Married FORCES?	DENT EVER IN U.S. AR 1 YES 2 XIII VE WAR OR DATES		If yee	SECENDENT OF Specify Cuban	, Mexican	, Puerto Rica		or No	Black	— American Indien, t, White, etc.
8	3 Widowed 4 Divorced	VE WAH OH DATES		י	res 2 X NO	Specify				Speci	™ White
2	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DE	CEDENT'S	USUAL OCCUP	ATION most of working	7	16b. KIN	D OF BUS	INESS/INI	DUSTRY	
	Elementary/Secondery (0-12) College (1-4)r 5+)		work done during se retired.)	The distribution of the state o	,					
MP	12 Yacars years		Sales					iller		SALOT	et
	Arthur Edward Steven	~					le (First, Middle)		iumame)		
H	19a, INFORMANT'S NAME (Type/Print)		b. MAILING	ADDRESS (Stre					State 7ie	Code	
2	Cora E. Stevens			Guyway					212		
	20e. METHOD OF DISPOSITION 1 N Burlat 2 Cremetion 3 Removal from State	20b. PLACE	AND DATE	OF DISPOSITION			OATE		ATION —	City or To	wn, Stata
	4 Donation 5 Other (Specify)	cernetery, cre Oak	matory or d Lawn	Cemete	ry 12	/12/	94	В	alti	more	, MD
	21. SIGNATURE OF AUNERAL SERVICE LICENSEE	() 0		DLIC	AND ADDRES	S OF FAC	eral I	Tome	of I	ounda	lk, Inc.
	Hean El	en	-		2 Wise						
	23. PART i. Enter the disease, or complications shock, or heart letters. List only one iMMEDIATE CAUSE (Final disease or condition resulting in desth)	that caused the de cause on each line).								Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.										
EDICAL	PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO								24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
W	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEA	TH Y	S I NO	□ UNCE	RTAIN					1 YES 2 NO
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is I	HOSFIIAL	: 2XXR/Outpetient 3	□ DOA	OTHER: 4 Nursing h	ome 5 🗆 Res	idence 8	Other (Sp	ecify)			
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B	1 Natural Pending 12-7		6:30	P M 1 [YES 2	NO S	SUBJECT	FELL	DOWN	STEPS	-
	3 Suicide 6 Could not be 4 Homicide determined	CE OF INJURY — At ho ling, etc. (Specify)	me, farm,	street, tectory, o	ffica		261. LOCATIO City or To	N (Street an wn, State)	d Number	or Rural R	oute Number,
		3333	L WALF	ORD DRIV	Ε		BALTIMO	RE, MA	RYLA	ND	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the be 2 MEDICAL EXAMINER: On the basis										and manner as stated.
띪	296. SIGNATURE AND TITLE OF CERTIFIER	lute no			29c. LICEN	C.M				E SIGNED	(Month, Day, Year) 08/94
2	30. NAME AND AGORESS OF PERSON WHO COMPLETED	111 P	enn	Stree	t, Ba	lti	more,	Maı	cyla	and	21201
	31. DATE FILD EC 1 2 1994 32. 1889	TRAPE SIGNATURE	ndell								

rmit. Pages 1. 2. 3 should

BALTIMORE, MARYLAND 21218-0020 24 hours after death. Page 6 may be retained by the hospital or TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for a befined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item # 16b Film # G 718 12-02-94 N.a Per funeral home

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR JOHN TILLERY W. SR DEC. 08 1994 8:55 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) MAR 25 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 212-46 0017 MONTHS DAYS HOURS 1 [X] M 2 | F 48 YRS. 1946 N.C. 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR Pages 1, 2, 3 IBERTY MEDICAL CENTER BALTIMORE CITY 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD ā BALTO 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? use as the burial-transit 2524 LOYOLA_NORTHWAY 21215 hours after death. Page 6 may be retained by the hospital or attending physician. Δ 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Ricen, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married Specify: BY 3 Wildowed 4 Divorced BLACK ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Police jo Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12TH funeral director, page 5 should be detached BALTO POLCE once. 17. FATHER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) RUBIN TILLERY 7 MARAGARET MOORE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 NANCY TILLERY 2524 LOYOLA NORTHWAY BALTO, MD 21215 pe 20e. METHOD OF DISPOSITION
1 √ Buriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 1 Donetion 5 Other (Specify) KING MEMORIAL PARK 12 29 4 RANDALLSTOWN MD the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY la MARCH f/H-WEST 4300 WABASH AVE the attending physician and completely filled in by the I Mental Hygiene prior to burial, cremation, or removal. 0 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each ilne. interval Batween **IMMEDIATE CAUSE (Final** Onast and Death t disease or condition resulting in death) Alles SCH DUE TO (OR AS A CONSEQUENCE OF) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate Cause Enter LINDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 01 PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate has with the State D HOSPITAL 1 TYES 2 NO Inpetient 2 KER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending 1 YES 2 NO BY After 1 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28 is DIRECTOR: / COMPLETED 8 Could not be 4 Homicide determined Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. TO THE FUNERAL D
be filed within 72 h
important: if in 25 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 분 DEC.09,1994 O.C.M.E. 0 30. NAME AND ADDRESS OF TEN CAUSE OF DEATH (ITEM 27) (Type, Print) HEODORE 111 Penn Street, Baltimore, Maryland 21201 MIK 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 nours after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal. notified at Pe examiner medical the event. traumatic prior to the attending physician Mental Hygiene prior to other 1 6 injury, signed by the Health and N AUR Health a Shows this certificate has been with the State Dept. of 23 The tem

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DIRECTOR: After the hours after death v

TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2

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Pages 1, 2, 3

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last)
SIDNEY 2. DATE OF DEATH MONTH 3. TIME OF DEATN TORY YEAR DEC. 6, 3 PM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
JULY 26,1927 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MARYLAND 218-26-2993 1 XM 2 - F 67 YRS 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH 4 WELLHAVEN CIRCLE, APT. 1421 OWINGS MILLS BALTIMORE RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE OWINGS MILLS 1 X YES 2 NO 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4 WELLHAVEN CIRCLE, APT. 1421 21117 IISA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black, White, alc. If yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: FORCES? 1 XES 2
IF YES, GIVE WAR OR OATES 1 Never Married 2 XXMarried 2 NO Specify 3 Widowed 4 Divorced WWII-NAVY WHITE 16a. DECEDENT'S USUAL OCCUPATION 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) PROPRIETOR TAILORING SHOP 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) SOL SAUL TOBY FANNY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE TOBY 4 WELLHAVEN CIRCLE, APT. 1421 OWINGS MILLS, MD21117 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Donation 5 Other (Specify) MARYLAND STATE VETERANS 12-8-94 OWINGS MILLS, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. moon 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition ALDIO PULMON resulting in death) DUE TO (OR AS A COL Sequentially list conditions, A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUE that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 ☐ YES 2 ☐ NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: HOSPITAL: OTHER 1 YES 2 3 DOA Home 5 Insidence 6 - Other (Specify) 27. MANNER OF BEATH 28a. DATE OF INJURY 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accider INJUR 1 YES 2 NO Investigation Accident 26a. PLACE OF INJURY — Al home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town State) 6 Could not be 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) MEDICAL EXAMINER: On the beels mination and/or investigation, in my opinion, desth occured at the time, data and placa, and due to the cause(a) and manner as stated. 295 SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, War DEATH (ITEM 27) (36%

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Pages 1, 2, 3 should permit. use as the burial-transit retained by the hospital or attending physician. for funeral director, page 5 should be detached once. To notified hours after death. Page 6 may be be must event, the medical examiner ystcian and completely filled in by the prior to burlal, cremation, or removal. the death certificate be executed traumatic the attending physician Mental Hygiene prior to other 0 been signed by th has be 23 OR ATTENDING PHYSICIAN: The certificate h marked, or DIRECTOR: After this c hours after death with 98 28 Hem TO THE HOSPITAL
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IMPORTANT: If II

94 36667 Item # 20c Film # G 718 12-12-94 N.A. Per Funeral Home FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 07 DAY 1994 YEAR DEC 11:15 MARION C. VANFOSSEN 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Ybar) Sept. 3, 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217 09 6693 MONTHS DAYS HOURS 1 M 2 F Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SHOCK TRAUMA CENTER BALTIMORE CITY ____ RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Pasadena Anne Arundel 1 YES 2 1 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 246 Cannoll Road 21122 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2
IF YES, GIVE WAR OR DATES
World War II It yes, specify Cuban, Maxican, Puarlo Rican, etc.) 1 Never Married 2 Married 1 YES 2X NO Specify: BY Specify: 3 🔯 Widowed 4 🗌 Divorced White ED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe П Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8th Ship Scaler Bethlehem Steel 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname William VanFossen Otellia Buny BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Richard VanFossen 246 Cannoll Road Pasadena, Maryland 21122 20a. METHOD OF DISPOSITION

1 Disposition 3 Disposition 3 Disposition 5 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE Maryland Manua Memorial Park Glen Haven 12/10 Glen Burnie Donation 5 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. Ritchie Hwy. Baltimore. Md. 23. PART I. Enter the diseases, pr inplications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart feiture List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onaet and Death disease pr condition hultiple Prymie rasulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE DE): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? TES 2 NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 XYES 2 NO Inpetiant 2 FR/Outpetiant 3 DOA

28e. DATE OF INJURY
(Month, Day, Year)

28b. Ti 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF INJURY 55 F M 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT peder trun accident 1 Natural 5 Pending 1 TES 2 NO 12/7/94 ВУ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Bran Annual 6 Mcl 3 Sulcide COMPLETED 8 Could not be 4 Homicide datarmined 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and pieca, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE hute mo O.C.M.E. DEC. 08,1994 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

> 111 32. REGISTRAR'S SIGNATURE

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TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If ten 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

_ S	FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEAL CERTIFICATE OF DE		HYGIENE REG. NO.
DEC	EDENT'S NAME	(First, M	dolle, Last)	2. DATE O	
	Francis	A.	Weiskittel	монтн Весен	nher 9

	1. DECEDENT'S NAME (First, Middle, Last							••	2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	Francis A. Weis										12:40P		
	4. SOCIAL SECURITY NUMBER 214-16-3035		MONTHS D		IF UNDER HOURS	24 HRS. MIN.	7. DATE OF (Month, I	Day, Year)	,1898 Maryland)		
	9a. FACILITY NAME (If not institution, give	street and number)	TAS VIL		9b. CITY, TO	OWN OR	LOCATIO	ON OF D	EATH		9c. COUNTY OF DEATH		
DIRECTOR	Chestrut Green Health		er		Tows	on					Bal	timo	re County
DIRE	Maryland Balt	imore			town or i		ON				10d. INSIDE (LIMITS?		
AL	10e. STREET AND NUMBER	1000				10f. Z	ZIP CODE				10g. CITI	ZEN OF W	HAT COUNTRY?
EB	6909 Bellona Ave	nue	Lower			2	2121	2		100		U.	S.A.
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1	NT EVER IN U.S. ARI I V YES 2 N		If y	es, speci		ı, Mexica	NIC ORIGIN? (an, Puerto Ric ly:		or No	14. RACE Black Specifi	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION in completed)	16a, DE	CEDENT'S U	ISUAL OCCU	UPATION	of working		16b. K	IND OF BUS	INESS/INC	USTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 8	life	Do NOT use	retired.)	my most	OF WOTHIN	v					
MP		4	Re	altor	2				R	eal E	stat	e	
8	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	IER'S NA	AME (First, Mid	dle, Maiden S	Sumame)		
BE	Anton	W	eiskitte	1			Em	ma	Charl.	otte		Carı	nine
2	19a. INFORMANT'S NAME (Type/Print)								Route Number,				
	Ford Weiskittel		8	03 S.	Mair	1 St	ree	t, G	eneva	, N.Y	. 14	456_	
	20s. METHOD OF DISPOSITION 1 XBuriel 2 Cremation 3 Red 4 Donation 6 Other (Specify)	movel from State	20b. PLACE A cemetary, crei	matory or oth	or place!			Dec.	DATE 14			City or Ton	Maryland
	21. SIONATURE OF FUNERAL SERVICE L		DECIC	MUGE	22 NA	ME AND	ADDRES	S OF EA	CH ITY			110,	TRILYTCHE
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	23. FART I. Enter the diseases, or shock, or haart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. List only one se	at caused the de use on sach line.							c or reapir	atory an	eat,	Approximate interval Between Onset and Death
LION	Sequentially list conditions, if any, leading to immediate):						YRS					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST d.												
	PART II. Other algorificent condition	no contribution to	doeth but out o		Abaranda	alota			David La			L	
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S	EXAMINER?	HOSPITAL:	7		OTHER:	-			heck only one)				
4	1 YES 2 NO 27. MANNER OF DEATH	28a, DATE OF	ER/Outpetient 3	26b. TIME		g Home Sc. INJUF		sidence	6 Other (Specify)	I III III OO	CHEED	
BY PI	1 Setural 6 Pending 2 Accident Investigation	(Month, I		INJU	IRY	WORK] NO	280. DESCI	TIBE HOW IN	IJURY OC	LOHED	
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE (building	OF INJURY — At hor, etc. (Specify)	me, ferm, st	reet, factory	, office				ION (Street a Town, State)	nd Number	or Rurel R	oute Number,
COMPLETED	- Alles	SICIAN: To the best of s											and manner as stated.
BB	295 SIGNATURE AND TITLE OF CENTIFI	$\cap X$	m-m			1	29c. LICE	·n/	MBER 570				(Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON W					t-b		м		21002			
	31. DATE FILED (Month, Day, Year) DEC1 2 1994		11s Road S	urce 3.	ZU; LU	cner	VIIIE	, Ma	ryland	21093			

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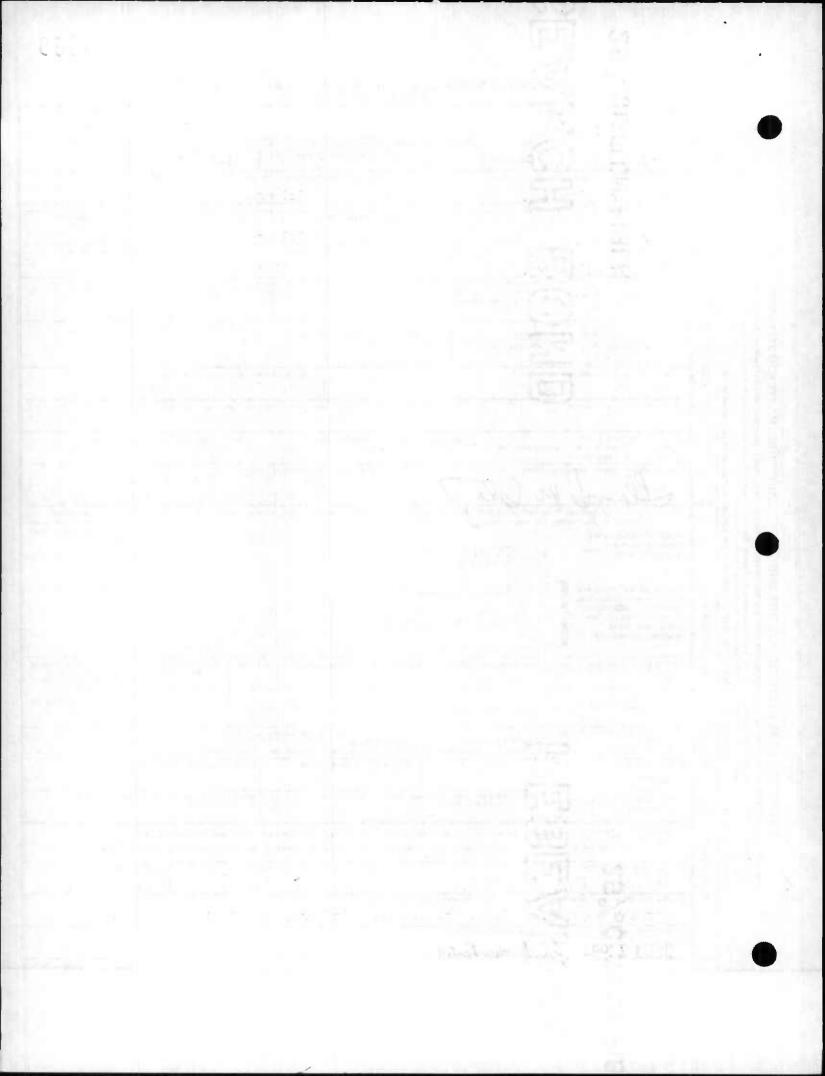
DIVISION OF VITAL RE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Abouts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 12 burial with the fact and whether 12 state Degit, of Health and Mental Thydren physician for the made of removal.

THE DIRECTOR: A contract of the property of the property of the made of the property of the property of the made of the property of the proper

	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND / DEPART CERTIFIC	MENT OF HEALTH		AL HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Lest) Donald Wilson	(EUGENE)		MON	E OF DEATH TH 2-03-9	24 **	3. TIME OF DEATH		
1	4. SOCIAL SECURITY NUMBER 217-38-5429	5. SEX 1 [XM 2] F	6. AGE (In yrs. last birthday) 53 YRS.	IF UNDER 1 YEAR IF UNDER MONTHS DAYS HOURS	MIN. (Mor	E OF BIRTIN ith, Day, Year) 1-13-4		BIRTHPLACE (State or Foreign Country) ALTIMORE, MD.		
TOR	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATN 1013 Brantley Ave. Baltimore									
DIRECTOR	100. STATE 10b. COUNT	TY	10c. CITY,	TOWN OR LOCATION Balt	timore			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	1013 Brantley	Ave.		101, ZIP COD	21217		USA	OF WHAT COUNTRY?		
B⊀	11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced			13. WAS DECENDENT (If yes, specify Cube 1 YES 2 X NO	en, Mexican, Puerto			RACE — American Indian, Black, White, etc. Specify: AFR • AMERICAN		
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5 +	(Give kind of wo	SUAL OCCUPATION ork done during most of world retired.)	ing 16	b. KIND OF BU	SINESS/INDUS	TRY		
BE CO	17. FATHER'S NAME (First, Middle, Last) ULYSSES WILS	ON		EI	7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	BRISCO	E WILS			
2	19e. INFORMANT'S NAME (Type/Print) EDITH WILSON			BRANNTLEY A						
	20s. METNOD OF DISPOSITION 1 Department of the properties of the									
	21. SIGNATURE OF FUNERAL SERVICE L	M. O.C.	7	22. NAME AND ADDREESTEP BROT				.A. MARYLAND 212		
CERTIFICATION	Sequentially list conditions, if any, lasding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	INAL AIDS (OR AS A CONSEQUENCE OF) (OR AS A CONSEQUENCE OF)	:						
MEDICAL	PART II. Other algnificent condition	o	deeth but not resulting in	the underlying cause	given in Part i.	24e. WAS APPERFO	RMED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF D	DEATN (Check only	one)				
	1 YES 2 X NO 27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF (Month, De	INJURY 28b. TIME	4 Nursing Nome 5 R OF 28c. INJURY AT WORK? M 1 YES 2	28d. D		INJURY OCCUR	RED		
TED BY	2 Acoldent Investigation 3 Suicide 8 Could not be determined									
COMPLETED			my knowledge, death occurred amination end/or investigation					ause(a) and manner se stated.		
()	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12 4 9									
TO BE	M. HAME AND ADDRESS OF PERSON W	NO COMPLETED CAUS	E OF DEATN (ITEM 27) (Type,	Print)	2414	7	12	GNED (MONTH, Day, Year)		
R R	Dorothy Snow, A	1.D., 10 N			, MD 2	1201	12	IGNED (Mopth, Day, Year)		



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permit. Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. F notified Pe must examiner THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the oean cerumans we would be the lined in by the I THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical experts. TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 2

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

SATPAL S.DANG MD.

31. DATE FILED (Month, Day, Year)

DEC1 2 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN George L. Wills 4:20 P.M 12-8-1994 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR 6. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS HOURS 1 X M 2 - F 213-07-4433 YRS. 81 Jan. 91 3 Maryland 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 101 Center Place, Apt. # 516 Dunda1k **Baltimore** RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Dunda1k 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 101 Center Place, Apt. 516 21222 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ▼YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 TES 2 NO ВУ Specify: 3 Widowed 4 Divorced White TT COMPLETED 18e, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 10 yrs Florist Grower 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) William Wills Kate BE Ledekar 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bertha Mennit 5th Ave. Dundalk, 6805 Md. 21222 20e. METHOD OF DISPOSITION
1 1 D Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Buriel 2 Cremetion 3 L 4 Donation 5 Other (Specify) Cemetery 121 12112 994 Baltimore, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins Bradley-Ashton Funeral Home, 21222 D00083 2134 Willow Spring Rd., Balto., Md. 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line interval Between IMMEDIATE CAUSE (Finel Onset and Dasth diseese or condition resulting in desth) DUE TO (OR AS A CONSCIUENCE OF): Hypertenscion CERTIFICATION

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE		, ,			
PART II. Other significent condition H. CONT. C. DID TOBACCO USE CONTI	licease	•		1 D YES	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATN (Check of	only one)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUP	RED
3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, ferm, street, facto	ory, office	281. LOCATION (Street City or Town, State	end Number or .	Rural Route Number,
	CIAN: To the best of my knowledge, de R: On the beele of examination end/or					
29b. SIGNATURE AND TITLE OF CERTIFIER	9		29c. LICENSE NU	MBER	29d. DATE S	IGNED (Month, Day, Year)

101 ST HELENA AVE. DUNDALK, MD. 21222

12-12-94 N.A. Per funagal Home
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - REGISTRAR		CE	RTIF	ICATE OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	George	D. Wi	llgug	hby		2. DATE	E OF OEATH	44	MEAD	3. TIME OF OEATH
- 1	6 086E C	* WILLE	UGHE	37				12	7	94	2204 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTN th, Day, Year)		8. BIRTI	NPLACE (State or Foreign
	243-38-6268	1 M 2 D F	67	YRS.	WOMING CATS	MOUNS MIN.		01-27			NC
_	9e. FACILITY NAME (If not institution, give				9b. CITY, TOWN	OR LOCATION OF DE	EATN		9c. CO	UNTY OF C	DEATH
DIRECTOR	UNIVERSITY HOSPIT	AL			BALTIM	ORE			BAI	TTMO	RE CITY
E I	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR LOCA	TION					10d. INSIDE CITY
		TIMORE CI	TY		BALTIMOR	E					1 TYES 2 NO
I A	10e. STREET AND NUMBER	A 7			10	. ZIP CODE			10g. Cl	TIZEN OF	WHAT COUNTRY?
9	3336 ST. AMBROSE	AVENUE				21215			UNI	TED ;	STATES
FUNERAL	11. MARITAL STATUS	12. WAS DECEOEN? FORCES? 1	YES 2 N	MED	13. WAS DEC	ENDENT OF HISPAN ecify Cuben, Mexica	VIC ORIGI	IN? (Specify Yes	or No-	14. RAC Blac	E — American Indian, k, White, etc.
BY	1 Never Merried 2XX Merried 3 Widowed 4 Divorced	IF YES, GIVE W	to 12-2		1 T YES	2 NO Specif				Spec	BLACK
8	15. DECEDENT'S EDU	ICATION			USUAL OCCUPATI	ON	16	b. KIND OF BU	SINESS/IA	IDUSTRY	DIAGN
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	(Gi	ve kind of	work done during me se retired.)	ost of working					
릴	11	conege (1-4 or 5 +	′ <u> </u>					CHE	MTCA	L co	
COMPLET	17. FATNER'S NAME (First, Middle, Last)					16. MOTNER'S NA	ME (First,				
BEC	KIT WIL	LOUGHBY				FANN	Y TII	RNAGE			
6	19e. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS (Street	and Number or Rural			n, State, Z	(ip Code)	
۲	LINDA THOMPSON		19	922 1	V. PATTE	RSON PARI	K AV	E. BA	LTIM	ORE.	MD 21213
	20e. METNOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Rem	noval from State	20b. PLACE A	ND DATE	OF DISPOSITION (N	ame of	DA	TE 20c. LO	CATION -	- City or To	own, State
	1 Burlel 2 Cremetion 3 Rem		GARF	RISON				2-94	OWIN	GS M	ILLS, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY (1.4 TYTY) TO A TYTY TO A TYT										
	· aboin &.	Will	dopla		(Garv	P. March	OTAM	H P A	1	LTTL	DMD
	23. PART i. Enter the diseasea, or ehock, or heart fellure.	complications that	ceused the de	eth. Do	not enter the mo	de of dying, suc	h aa ce	rdiec or reap	iratory a	rreat,	Approximate
ı	IMMEDIATE CAUSE (Finei	Clet brilly blie Cau	ee Dii eeçii iiile.								Onset and Death
	disease or condition resulting in death)	Par	OS AS A CONSEC	LN	lass						
		200			F):						
ON	Sequentially list conditions,	W-	umon	_							
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Please or Island) CAUSE (Please or Island)										
FI	CAUSE (Disease or Injury thet initieted events		OR AS A CONSEC			DISCUE	1				
E	resulting in deeth) LAST	4									1
8		0.									
DICAL	PART II. Other aignificant condition				in the underlyin	g cause given in	Pert i.	24a. WAS AN PERFOR		241	MAILABLE PRIOR TO
20	LOVOVIARY THAT VIXA IC									COMPLETION OF CAUSE OF DEATH?	
ME	Diabetes										1 TYES 2 NO
Z	DID TOBACCO USE	CONTRIBUTE	TO CAUS	SE OF							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. P	LACE OF DEATH (Ch	eck only o	one)			
14S	1 YES 2 NO	1 Inpatient 2 -				te 5 🗆 Residence					
	1 Natural 5 Pending	28e. DATE OF (Month, Da		28b. TIN	JURY WO	JURY AT DRK? YES 2 NO	28d. DE	SCRIBE NOW I	NJURY O	CCURED	
BĄ	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF	F INJURY — At hor	me term	street, fectory, offic		201.10	CATION (Street	and Mumb	ne ne Guard	Doub Mumbus
8	4 Nomicide 8 Could not be	building,	etc. (Specify)		,			y or Town, Stete)		er or narer	Note Namber,
9	290. CERTIFIER AND CERTIFYING PAYO	SICIAN: To the heat of	mu language de de				17.17.41				
COMPLET	(Check only one) 296. CERTIFYING PNYS CERTIFYING PNYS MEDICAL EXAMINI										e) end menner ee stated,
8	29b. SIGNATURE AND TITLE OF CERTIFIE							e end place, el			
H	PLAINTING SIN	Jana Al	w			29c. LICENSE NUI	4		29d. DA	1 SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	NO COMPLETED CALIS	E OF DEATH (ITEM	4 27) (Time	Print)	Residen	ℓ_1			01/	1-14
	CUMPINA Sol	CANA	77 9	Gra	PINE SL	Baltiv	vall	MD	217	201	
	31. DATE FILED (Month, Day, Year)	32. BEGISTRA	R'S SIGNATURE	0100	N (C O)	COUNTY	- 01 (100	-1	-	
	DEC 1 9 400	161.4									j j

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within cours after death. Page 6 may be retained by the host	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	Item # 1 Film # g 71	8 12-12-94	N.A.	Per fune	ral	home						14	30012	
	1 - FOR STATE REGISTRAR	STATE OF M		D / DEPAR					MENTA	L HYGIEN REG. NO.	E			
- 8	1. DECEDENT'S NAME (First, Middle, Last)			-					2. DAT	E OF DEATH	,199		3. TIME OF DEATH	
	Lucius	-E. ₩.	Wi	.1kers	on	, Jr			De	9:30 P M				
- 8	4. SOCIAL SECURITY NUMBER	5. SEX		s. last birthday)		ER 1 YEAR	IF UNDER		7. DATE	OF BIRTH (h, Day, Year)		8. BIRTHI	PLACE (State or Foreign	
	276-20-0141	1 X M 2 🗆 F	67	YRS.	MONTHS	DAYS	HOURS	MIN.		7. 1927		Country	Ohio	
	9e. FACILITY NAME (If not institution, give s				9b. CIT	TY, TOWN C	R LOCATI	ON OF OR		/ <u> </u>	9c. COU	NTY OF DE		
S S	Maryland General Hos	pital			Ba	lto								
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			7										
2		Y				OR LOCAT	ION						10d. INSIDE CITY LIMITS?	
	Md 10e. STREET AND NUMBER			Bd	lto								1 X YES 2 NO	
BY FUNERAL							ZIP COO	_					HAT COUNTRY?	
핗	4106 / Glenhunt	-					1229				U S			
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1			13	If yes, so	ENDENT C	OF HISPAN	NIC ORIGI	N? (Specify Yea Rican, etc.)	or No-	14. RACE Black	- American Indian, White, atc.	
≥	1 Never Married 2 W Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	4 A	- 1		2 NO					Specif		
	15. DECEDENT'S EDU	CATION	1400	. DECEDENT'S		0.001.01.01							DIACK	
ш	(Specify only highest grade	completed)		(Give kind of life. Do NOT up	work done	e durina mo	st of worki	ng	16	b. KIND OF BUS	INESS/INC	USTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Forem		,				Balti	more	Wate	ir.	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			1 01 6111	ан		40.000		115 (5)	Middle, Maiden		Wate		
	Lucius W. Wilkers	son. Sr								Sorre				
BE	19a. INFORMANT'S NAME (Type/Print)	3011, 31		105 144 11 1010	A CODE	00 /04								
2									d Balto, Md 21229					
										* 1 1				
	20a. METHOD OF DISPOSITION 1	oval from State	cometery	cremetory or o	ther place	mat o	me or			20c. LO	ATION -	Caton	le , Md	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	1110			. NAME A		SC OF FA		234 -0 0	0031		16, 110	
	1100					Marc								
	Dladus	wou	ren)		4300	Wa	hash	Ave	nue Ba	lto.	Md 2	1215	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate													
	IMMEDIATE CAUSE (Finel										Intarval Between Onset and Death			
	disease or condition resulting in death)	Pr	neumo	nia									2 days	
	an and a supply of	DUE TO	OR AS A COP	NSEOUENCE O	F):									
Z	Sequentially list conditions,	b												
CERTIFICATION	If any, leeding to immediate	DUE TO	OR AS A CON	NSEQUENCE O	F):									
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c												
E	that initiated events resulting in deeth) LAST	ODE 10 (OH AS A CON	NSEQUENCE O	ተ):								i	
병		d												
	PART II. Other significent condition	s contributing to	death but n	ot resulting	In the u	ınderlying	ceuse s	given in	Part I.	24s. WAS AN			WERE AUTOPSY FINDINGS	
MEDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									_	1 XYES 2	_ 110		OF DEATH? 1 YES 2 □ NO	
-	DID TOBACCO USE C	ONTRIBUTE	TO CA	USE OF	DEA	TH Y	ES 🖂	NO					143 123 2 110	
A	25. WAS CASE REFERRED TO MEDICAL						ACE OF D		eck only o	ne)				
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatien	# 3 □ DOA	OTHE									
Ŧ	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ		ratuelice	_	SCRIBE HOW II	JURY OC	UREO		
	1 Natural 5 Pending	(Month, Da	ly, Year)	IN.	JURY		RK?	NO						
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF	INJURY — A	t home, ferm,	street, te	ctory, office			28f. LO	CATION (Street a	nd Number	or Rural Ro	oute Number	
	4 Homicide determined	building, s	etc. (Specify)							or Town, State)				
COMPLET	29e. CERTIFIER 1 XCERTIFYING PHYSI	CIAN: To the heat of	my kanada i U	doub		M-		70 m		50. F. W	Sinday C	20		
MP	(Check only one) 1 XCERTIFYING PHYSI 2 MEDICAL EXAMINE													
8					, my	Jennon, 0				a arru prace, an				
BE	296. SIGNATURE AND TITLE OF CERTIFIER	urans	60.5-	N	2		29c. LICI	892	24		29d. DAT		(Month, Day, Year)	
_	I cell cons rucce	NTWO SI	acci 5	1-1								17-	06-94	

c/o Maryland General Hospital

Tatiana Mouravskaia,
31. DATE FILEO (Month, Day, Year)

DEC 1.2 1994 M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and heart. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICUS

	1 - STATE REGISTRAR	OINIE OI (CE	RTIF	ICATE	OF	DEAT	TH I	MENIA	REG. N			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATN	DAY	YEAR	3. TIME OF DEATH
	CARL	ANDRE	W	ZAPFFE					DEC. 8, 1994			м.	
	4. SOCIAL SECURITY NUMBER	5. \$EX	t birthday)	IF UNDER	1 YEAR	IF UNDER			OF BIRTN		6. BIRTI	NPLACE (State or Foreign	
	221-03-6268	1 M 2 F	82	YRS.	MONTHS	DATS	HOURS	MIN.		Y 25,			NESOTA
13	9e. FACILITY NAME (If not institution, give s	treet end number)			9b. CITY,	TOWN O	R LOCATION	ON OF DE	ATN		9c. CC	OUNTY OF E	DEATH
OH	6410 MURRAY HILL RESIDENCE OF DECEMENT	ROAD			BA	LTIM	ORE				1	BALTI	MORE
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			ine CIT	Y, TOWN C	B LOCAT	ION						10d, INSIDE CITY
E I		LTIMORE			LTIM		ION						LIMITS?
	10e. STREET AND NUMBER	LITHORE		DA			ZIP CODE	:			100 0	ITIZEN OF	WHAT COUNTRY?
R/	6410 MURRAY HILL	ROAD					212				103.0		SA
BY FUNERAL	11. MARITAL STATUS	12 WAS DECEDEN	IT EVER IN U.S. ARI	MED	13. 1	WAS DECI			IIC ORIGIN	17 (Specify	Yes or No-	14. RAC	E — American Indian.
7	1 Never Merried 2 Merried	FORCES? 1 IF YES, GIVE W	YES 2 N	10	1 1	t yes, spe		n, Mexica	n, Puerto	Rican, etc.)		Blac Spec	k, White, atc.
	3 Widowed 4 Divorced	l					2%	,					WHITE
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gh	ve kind of	USUAL OC	CCUPATIO	N st of workin	g	16b	. KIND OF	BUSINESS/I	NDUSTRY	
9	Elementery/Secondary (0-12)	College (1-4 or 5	+) life.		se retired.)	am.				ar	nnn-		
M	1.2 17. FATNER'S NAME (First, Middle, Last)	5		SCI	ENTI	ST					FEEL		
	CARL			ZAPF	יבורו			THEL		Middle, Maid	len Surname		BERG
BE	19s. INFORMANT'S NAME (Type/Print)		100			(21				01	fown, State,		DING
2	DENISE ZAPFFE											D. 21	212
	20s. METHOD OF DISPOSITION		20b. PLACE A						DAT				
	1 Buriel 2 Cremetion 3 Rem	oval from State	EVERGE			111011111111			DAI	DATE 20c. LOCATION — City or Town, State BRAINERD, MINNESO			
	21. SHORATURE OF PUREPAL SERVICE NCENSEE JOHN E. DOLAN 22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC.												
	* Alohn Eva	lanjohn	E. DOLAN		1								. 4
-	23/PART I. Enter the diseases or o											2120	
	ahock, or heart failure. List only one cause on each line.											Approximata interval Between	
	IMMEDIATE CAUSE (Final disease or condition	. METAST	huir Cla	49	YEAS	nia	J						Onaet and Death
	resulting in death)	DUE TO	(OR AS A CONSEQ	EQUENCE OF):									•
z	CARCINOMA OF PROSTATE											1118	
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	с											
T	that initiated eventa resulting in death) LAST	DUE 10	(OR AS A CONSEC	UENCE O	F):								
H	robuiting in doubly Exer	d											
7	PART II. Other significant condition	a contributing to	death but not re	esuiting	in the un	derlying	cause g	iven in	Part I.		AN AUTOPS	Y 24b	. WERE AUTOPSY FINDINGS
DICAL											2 NO		AMILABLE PRIOR TO COMPLETION OF CAUSE
MEC							/				2 (9****)	Ì	OF DEATH?
ä	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEAT	TH YE	S 🗆 N	10 N	UNC	ERTAIN					
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	носпіта	26. PLACI	E OF DEA	TN (Check o			/					
Si	1 TYES 2 NO	HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER		5 NA	eldence	6 🗆 Othe	r (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF (Month, D	INJURY lay, Year)	28b. TIM	E OF URY	28c. INJU WOR			28d. DES	CRIBE HO	V INJURY O	CCURED	
BY	1 Netural 5 Pending 2 Accident Investigation				M		ES 2	NO					
								et and Numb	er or Rural I	Route Number,			
COMPLETED	4 Nomicide determined												
7	290. CERTIFIER (Check only	CIAN: To the best of	my knowledge, des	ith occum	ed at the ti	me, date	end place,	end due	to the cau	ree(e) end r	nanner ee a	tated.	
S S	2 MEDICAL EXAMINE	R: On the beele at a	xamination end/or in	nveatigatio	on, in my o	pinion, de	eth occur	ed at the	time, date	end place,	end due to	the ceuse(e	e) end menner ee stated.
BE C	296 SIGNATURE AND TITLE OF CERTIFIER	1/1	4	10.11.0	^		29c. LICE	NSE NUM	IBER		29d. D/	ATE SIGNED	(Month, Day, Year)
10 B	Marcis Ill	Mun	nan	WV)		DO	76	de	7	•	121	9194
F	30. NAME AND ADDRESS OF PERSON WHO								1	-			
	DR. MARCIO MENENI			R. TO	OWSON	, MI	٠.						
	31. DATE FILED (Month, Day, Year) DEC1 2 1994	32. REGISTRA	R'S SIGNATURE										
311		AND DISCOURSE OF THE PERSON OF											

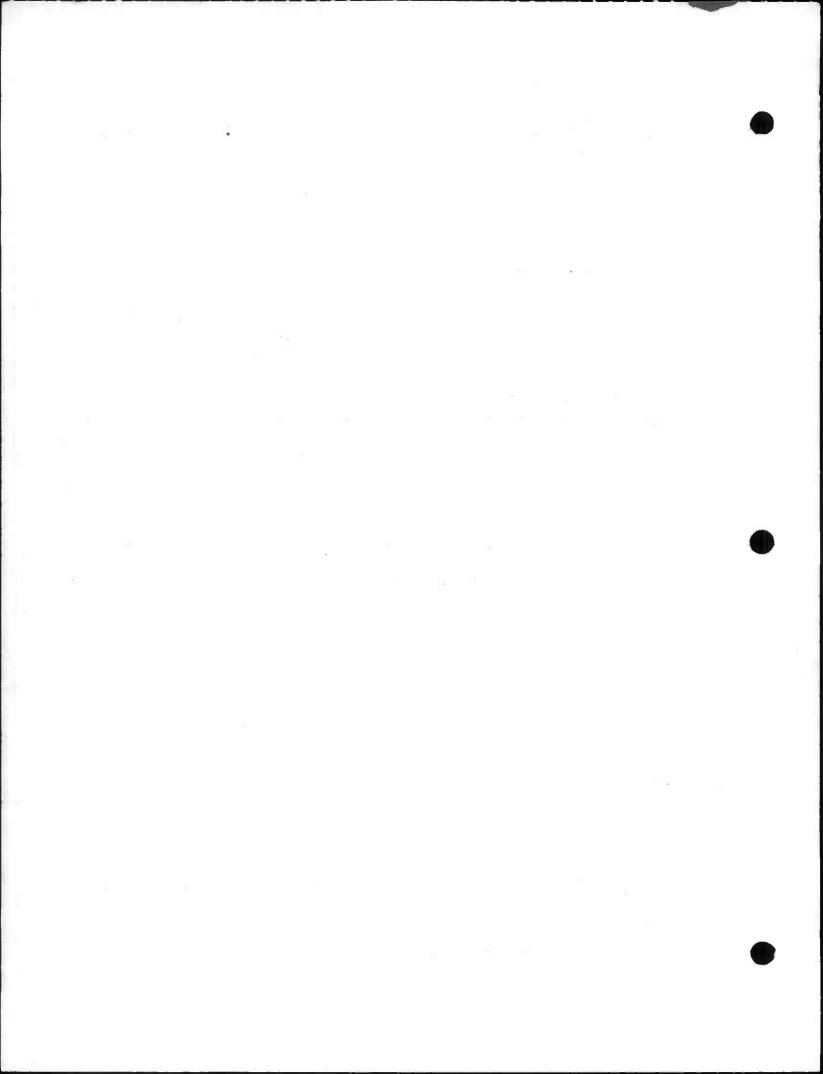
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0,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rema	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medic
9/	A De	ошо	P. C.	EVE
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ecut	Dd C	buris	atic
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L.	SICI	Cert	h th	d, 0
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0400	inding physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	
	rSICIAN: The law requires that the death certificate be executed within more after a team Page 6 may be retained by the hospital or attending physician.	hould be detached for use	iflad at once
	suffi. Page 6 may be ret	uneral director, page 5 s	d or Hem 23 shows any influx or other traumatic event the medical armines must be notified at once
	within nows after de	pletely filled in by the t cremation, or removal	sent the madical as
	certificate be executed	certificate has been signed by the attending physician and completely filled in by me. In the State Dept. of Health and Mental Hygiene prior to burial, cremation, for removal.	or other traumatic ex
. ()))	requires that the death	been signed by the atter	shows any injury o
	YSICIAN: The law	s certificate has	d or Item 23

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM CERTIFICA	ENT OF H	EALTH AND	MENTAL	HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			TIME OF DEA	TH	
	GEORGIY Z	VEGINTSE	E V			MONTH	07	92	EAR	3:30	PM	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs	s. last birthday) F	IF UNDER 24 HRS.	24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State of Foreign							
	213-37-7453	1 X M 2 □ F	34 YRS. MON	THS DAYS	HOURS MIN.		G. 19	1910	Country)			
	9a. FACILITY NAME (If not institution, give stre	et and number)	9b.	CITY, TOWN O	R LOCATION OF D			9c. COUNTY				
DIRECTOR	SINAI HOSPITAL BALTIMORE											
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY, TO	WN OR LOCATI	ON				Ti	od, INSIDE CIT	v	
8	MARYLAND									LIMITS?		
	10e. STREET AND NUMBER			BALTIM 101.	ZIP CODE	-		10a, CITIZEI		AT COUNTRY?	NO	
FUNERAL	3620 FORDS LANE,	λDT F			21215	5		,				
5		12. WAS DECEDENT EVER IN U.S	S. ARMED	13. WAS DECE	NDENT OF HISPAI	NIC ORIGIN	? (Specify Yes		USSI RACE -	- American ind	lan,	
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	XNO		cify Cuban, Maxica 2 NO Specif		lican, atc.)		Black, Specify:	White, etc.		
										WHITE		
	15. DECEDENT'S EDUCA (Specify only highest grade of	TION 16st ompleted)	(Give kind of work of the Do NOT use reti	done during mos	N t of working	16b.	KIND OF BUS	SINESS/INDUS	TRY			
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	and. DO 1101 USB 1811									
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	4		ENGIN	EER 16. MOTHER'S NA	ME /Elect A		AEROSP	ACE			
		NUCLEN					nuule, Maluen	<i>Sumame</i>				
BE	19a. INFORMANT'S NAME (Type/Print)	NTSEV	19b. MAILING ADD	RESS (Street an	ELENA d Number or Rural		er, City or Tow	n, State. Zip Co	ocie)			
임	MRS. YELIZAVETA	MEYERSON NOSC			LANE, A					21215		
	20a. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Remov		ACE AND DATE OF DI		ne of	DATE	20c. LO	CATION — City	y or Town	n, Slata		
	4 Donation 5 Other (Specify)		INGTON—C	HIZUK .	AMUNO 12	2-9-9	4 BALT	TIMORE	, ME)		
	21. SIGNATURE OF FUNERAL SERVICE LICE	WSEE			ADDRESS OF FA		DOC	TATO				
	b Chy (Uni	Zuin			LEVINSON REISTER				TMOD	E MD	21211	
П	23. PART I Enter the diseases, or do	mplicetions that caused the	a death. Do not e	enter the mod	e of dying, auc	h as cerd	lec or respi	ratory arrest	LINOR L	Approxim		
	IMMEDIATE CAUSE (Fine)	n only one cause on each	lina.							interval E		
	disease or condition resulting in deeth)	CEREBROVA DUE TO (OR AS A CON	SCULA	R ACC	INEN	T				13 00	7.41.3	
		DUE TO (OR AS A COR	NSEQUENCE OF):								9	
Z	Sequentially liet conditions, b.	HYPERTE	NSION							>5 y	ears	
AŢ	if any, leading to immediate	DUE TO (OR AS A COM		AT	1011					>5		
FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CON		-6/7/1	010					139	cars	
CERTIFICATION	resulting in death) LAST	,	,							j		
	0.									+		
AL	PART ii. Other eignificant conditions	contributing to death but n	ot reculting in th	e underlying	ceuse given in	Part i.	24a. WAS AN PERFOR			ERE AUTOPSY F		
8						_	1 [YES 2	NO NO	C	OMPLETION OF F DEATH?		
M									1	YES 2	NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI				UNCERTAI	N						
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	PLACE OF DEATH (C	HER:							-	
¥ l	1 YES 2 NO	28a. DATE OF INJURY	28b. TIME OF	Nursing Home 28c. INJU	5 Residence			11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-			
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WOR	K?	200. DEŞI	CHIBE HOW II	NJURY OCCUR	ŒD			
Accident Street and Number or Rural Route Number or Rural Rout									Rumit Rou	ite Number		
										1		
٦ ا	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowledge	a, death occurred at	the time date of	and place, and due	to the cour	e(e) and man	nos so stated				
<u>\S</u>		On the beals of exemination and							auso(a) a	nd manner as	stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI					fonth, Day, Year)		
B	Connie M. 42:00	M.D. Rocin	lont		7524023:		29841	► 17/·	7 19	Unit, Dilly, 1687)		
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print					14	1/1	/		
	Connie McRi	11 M.D. S	ina Ho	spita	0 of.	Balt	imor	e				
j	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	RE	-7		100 11					-	
II.	DEC1 2 1994 Ju	4 devoter head	11								ı	





	FOR 1 - STATE REGISTRAR	STATE OF	MARYLAND	/ DEPAI	RTMENT (OF HE	ALTH	AND I	MENTAL HYG			
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEAT	н	-	3. TIME OF CEATH
	Mary Grace Aff	ayroux							12"	194 1	994	1000 AM
	4. SOCIAL SECURITY NUMBER 219-03-4199	5. SEX	6. AGE (In yrs. I	est birthday) YRS.	IF UNDER 1 Y	_	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Yea 3-26-1	1	8. BIRT	HPLACE (State or Foreign try)
	9a. FACILITY NAME (If not institution, give :	street and number)	. , ,		9b. CITY, TO	OWN OR	LOCATE	ON OF OE			UNTY OF C	
DIRECTOR	217 McHenry Ave.				Pike	svi	lle			В	alti	more
RE	10a. STATE 10b. COUNT	Υ		10c. CI1	Y, TOWN OR E	OCATIO	N					10d. INSIDE CITY
	Maryland Bal	timora			Pikesv	_						1 TYES 2 XNO
FUNERAL	217 McHenry A	ve.					2120			10g. Ci	U.S	what country? • A•
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		TEVER IN U.S. A TEVER IN U.S. A TEVER IN U.S. A TEVER IN U.S. A TEVER IN U.S. A	AMED NO	If yo	s, spec	Ify Quba	of HISPAN n, Mexica Specify	IIC ORIGIN? (Specifin, Puerto Rican, etc.	Yes or No—	14. RAC Blac Spec	E — American Indian, k, White, etc.
8	15. DECEDENT'S EDU (Specify only highest grade	CATION	18e. D	ECEDENT'S	USUAL OCCU	PATION	-		18b. KIND OF	BUSINESS/IN	IDUSTRY	111111111111111111111111111111111111111
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	- 44	Give kind of le. Do NOT u	work done durii se retired.)	ng most	of working	ng .				
MP	8		F	loor	Lady				La	undry		
8	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Ma			
BE	William C. Affay	roux							la S. Wi			
2	19a. INFORMANT'S NAME (Type/Print) William A. Hurlo	ala.							Route Number, City or			24450
						_		Ra.	Westmin			
	20g METHOO OF DISPOSITION 1 A Burlai 2 Cremetion 3 Ram 4 Donation 5 Other (Specify)	oval from State			of disposition ther place!			12 1	0ATE 200	LOCATION -	- City or To	own, Stata
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Drule	1 KIU				SS OF FAC		PIKesv	ттте	, FID.
	. J. Houth	Ellard	8		Eck	har	dt 1	fune:	ral Chap		gs M	ills, MD. 2°
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory strest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF):											
C	PART II. Other algnificant condition	s contributing to	death but not	reaulting	In the under	lvina d	ause o	ilven in l	Part J. 24a WAS	AN AUTOPSY	246	. WERE AUTOPSY FINDINGS
: MEDICA	Metas tatic	livea	d con	neer					PER	FORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL				2	6 PLAC	E OF OF	FATH /Che	ck only one)			
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient	3 🗀 noa	OTHER:		1					
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM		. INJUA	Y AT	ardenca	8 Other (Specify) 28d. DESCRIBE HO	W INJURY OC	CURED	
	1 Natural 5 Pending Investigation	(Month, D	ay, Year)	INJ	M 1	WORK	7 2 [NO				
2 Accident Investigation M 1 YES 2 NO 2 Accident 3 Suicide 6 Could not be defarmined 28a. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State) 28a. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State)								r or Rural F	Route Number,			
COMPLE		CIAN: To the best of) and manner as stated.
- 111	29b. SIGNATURE AND TITLE OF CERTIFIER		/		, , ,			NSE NUM				
BE	Whelen C. l.s.	With	T2n	mare I		1	1	24	3 -6	29d. DAT	/ 2/	(Month, Day, Year)
٥	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	SE OF OEATH (ITE	M 27) (Type,	1	/	2	11	10/		6	- 1 / /
	31. OAPE, FILED (Month, Day, Year)	32, REGISTRA	R'S SIGNATURE	1	the	1	Jal	17	iven o	1/22	7	
	DEUI 3 1994 de	in Havilen	Red									

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CONTRACTOR SERVICE

3. TIME OF DEATH

6. BIRTHPLACE (State or Foreign

Maryland

Baltimore

14. RACE — American Indian, Black, White, etc.

10d. INSIDE CITY

1 YES 2 NO

White

Intervel Between

Onset and Death

Not apple

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

OF DEATH?

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

USA

Specify:

2. DATE OF DEATH

Dec. 10,1994

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Elmer

Altvater

David

4. SOCIAL SECURITY NUMBER

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6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH NOV . 8,1929 220-24-7838 1 [X] M 2 | F 65 YRS. DAYS HOURS permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 312 Lorraine Ave. Essex RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Baltimore Md/ Essex 10e. STREET AND NUMBER 10f. ZIP CODE FUNERAL the funeral director, page 5 should be detached for use as the burial-transit 312 Lorraine Ave. 21221 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Pusrio Rican, stc.)
1 YES 2X NO Specify: after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind at work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL boat yard 8th carpenter at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Vivian White Charles Altvater notified 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 312 Lorraine Ave. Baltimore Md.21221 Sherry Malcolm pe 20s. METHOD OF OISPOSITION

1 XBurist 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Cemetery 12/12/94 Baltimore Md. Lawn examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart painting. List only one cause on each line. filled in by executed within hours 0 IMMEDIATE CAUSE (Final the cremation, disease or condition and completely fi burial, cremation resulting in daeth) traumatic event, DUE TO (OR AS A CONSEQUENCE CERTIFICATION and Sequentially list conditions, prior to If any, leading to immediate cause. Enter UNDERLYING signed by the attending physician a Health and Mental Hygiene prior to requires that the death certificate be CAUSE (Disease or injury other that initiated evente resulting in deeth) LAST 10 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL AUR 1 YES 2 NO shows ; this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item **EXAMINER?** HOSPITAL OTHER: 1 YES 2 NO 1 Inpetient 2 I ER/Outpetient 3 I DOA 4 - Nursing Homs 5 Sesidence 6 - Other (Specify) 0 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1/ Natural DIRECTOR: After the hours after death w 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At homs, farm, atrest, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 49 3 Suicide COMPLETED 6 Could not be 28 4 Homicide Item OR. 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and manner as stated. THE FUNERAL D HE within 72 h DRTANT: If It THE HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 墨墨) g BEN

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

J 04N

DEC1 3 1994

J. LOH

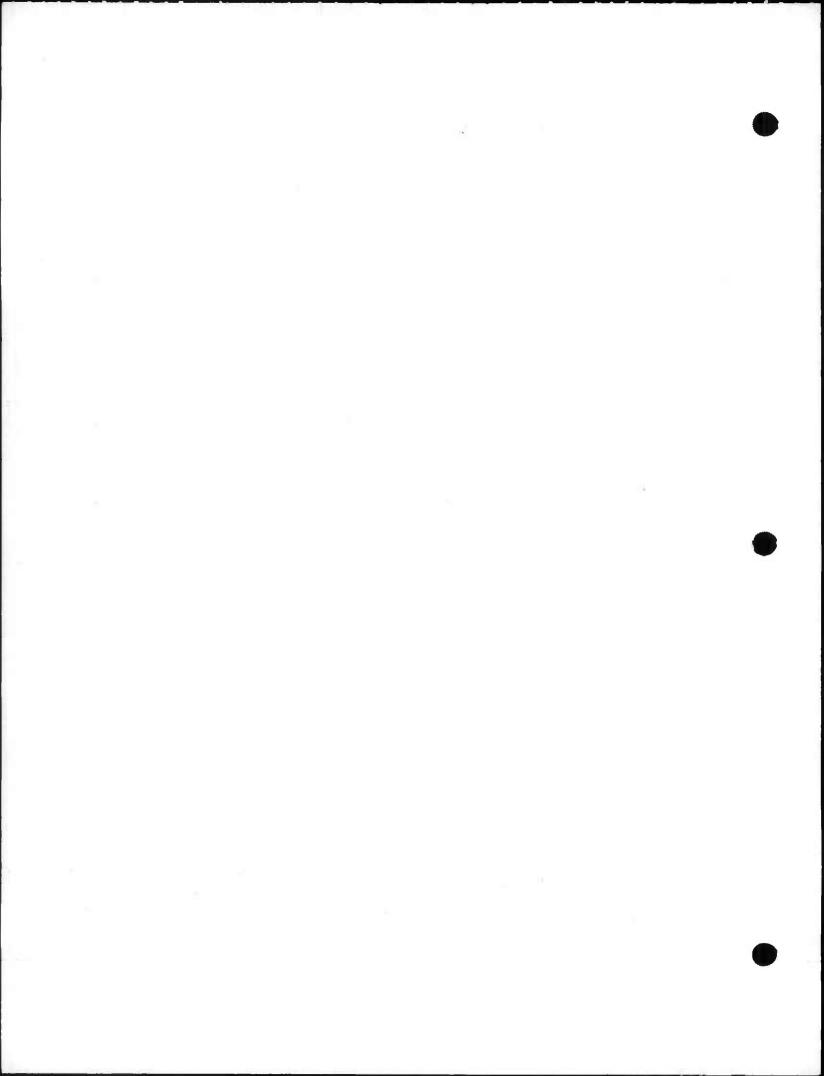
32. REGISTAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Stemmers

617A

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Item # 17 Film # G 718 12-13-94 N.A. Per funeral home

9	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
1	1. DECEDENT'S NAME (First, Middle, Last) ARLENE	ANDERSON				2. DATE OF DEATH DECEMBER	B',1994'	3. TIME OF DEATH 10:10 A M		
3	4. SOCIAL SECURITY NUMBER 250–46–9609	1 🗆 M 2 😾 F		HTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar. 4, 1		BIRTINPLACE (State or Foreign Country) Carolina		
TOR	9a. FACILITY NAME (If not Institution, give s THE JOHNS HOPKI		91		ORE CITY		9c. COUNTY	OF DEATH		
DIRECTOR	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY N		own or Locat	ION		10d. INSIDE CITY LIMITS?				
FUNERAL	100. STREET AND NUMBER 560 Baker Street		Dair	101.	ZIP CODE 21217		10g. CITIZEN	1 YES 2 NO N OF WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 X NO	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yen, Puarto Rican, etc.)		RACE — American Indian, Black, Whita, atc. Specify:		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondary (0-12)	CATION ocompleted) College (1-4 or 5+) N/A	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mos tired.)	N st of working	16b. KIND OF BU				
OM	17. FATNER'S NAME (First, Middle, Last)	N/ A	Factory W	orker	18. MOTNER'S NA	Wareh				
BE	Dave Croomef Dav	e Croomer			Louise 1					
2	19a. INFORMANT'S NAME (Type/Print) Shirlene McCray					noute Number, City or Town				
	20a. METHOD OF DISPOSITION 1	oval from State 20b.	PLACE AND DATE OF C	ISPOSITION (Na	me of	DATE 20c. LC		or Town, Stata		
	21. SIGNATURE OF FUNERAL SERVICE LICE Bernard D			22. NAME AN March	Funeral	Home East		e, MD 21202		
CERTIFICATION	23. PART i. Enter the diseases, or shock, pr heart fellure. IMMEDIATE CAUSE (Final disease pr condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease pr injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF:	enter the mod	de of dying, auch	Syndron	iratory arrest	Approximate intervel Between Onset and Deeth one with		
PHYSICIAN: MEDICAL CI	PART ii. Other eignificant condition					1 YES 2	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
/SIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Unpetient 2 - ER/Outp		THER: Nursing Nome	5 Residence	8 Other (Specify)				
ВУ РН	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Oay, Year)	28b. TIME O	M 1 Y	RK7 ES 2 NO	28d. DESCRIBE HOW	HOW INJURY OCCURED			
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Speci	— At home, ferm, atree	et, fectory, office		28f. LOCATION (Street City or Town, State)	and Number or I	Rural Route Number,		
COMPLETED		CIAN: To the best of my knowler. R: On the basis of examination						Puse(a) and mannar as stated.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	am n			29c. LICENSE NUM	BER	29d. DATE SI	GNED (Month, Day, Year)		
-	30. NAME AND ADDREST OF FERSON WHO	O COMPLETED CAUSE OF DEA	Hopkins		ral, Bo	Himore,	M			
	DEC 1 0 1004	A.C. SIGN		•						

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		1 - STATE REGISTRAR		OMIL OF	··/	CERTIF			DEATH	INCI	REG. NO.			
		1, DECEDENT'S NAME (Firs	I, Middle, Last)							2.	DATE OF OEATH			. TIME OF DEATH
		ALICE	Τ.		ATWO)OD				D'	ÉCEMBER º	8,19	94"	8:45 P M
		4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. last birthday)	IF UNDE	DAYS	IF UNDER 24 HRS.	7. [Month, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign
29		043/12/415		1 M 2 XXF	73	YRS.	MONTHS	DAYS	HOURS MIN.		7/1/1921		can	ada
3 should	-	9e. FACILITY NAME (If not in							OR LOCATION OF	DEATH			TY OF DEA	
2	DIRECTOR	NORTH ARUN	DEL HOS	SPITAL A	<u> SSOCI</u>	ATION	G	LEN	BURNIE			A.A	. COI	JNTY
Pages 1,	E C	10e. STATE	10b. COUNTY			10c. CI1	Y, TOWN	OR LOCAT	TION				1	Od. INSIDE CITY
- Pag	B	MD	A	λA			GLEN	BUR	NIE				,	LIMITS?
permi	AL	10e. STREET AND NUMBER							ZIP CODE			10g. CITIZ		AT COUNTRY?
020 physician. burial-transit permit.	FUNERAL	25 BROW	NSHADE	DRIVE					21061			USA		
Siciar Tal-tra	5	11, MARITAL STATUS		12. WAS DECEDED	T EVER IN	U.S. ARMED	13.	WAS DEC	ENDENT OF HISP ecify Cuben, Mexi	ANIC O	RIGIN? (Specify Yes	or No-	14. RACE -	- American Indian, White, etc.
fing phy	ВУ	1 Never Married 2 SX Widowed 4 Div		IF YES, GIVE					XX NO Spe		erio riicari, etc.)			white
215-0020 attending physic			CEDENT'S EDUC	ATION		18e. DECEDENT'S	1101101 6			_		1		
21215 al or attend for use as		(Specify on	ly highest grade o	completed)		(Give kind of life. Do NOT u	work done	during mo	st of working		16b. KIND OF BUS	SINESS/INDU	STRY	
D 2 Spital	PLE	Elementary/Secondary (0-12)	College (1-4 or 5	*)	HOMEM					OWN	HOME		
LAND 21215-0020 the hospital or attending physician. detached for use as the burial-tranonce.	COMPLETED	17. FATHER'S NAME (First, A	Aiddle, Last)						18. MOTHER'S P	IAME (F	First, Middle, Maiden			
YL be at a	BE C	FRA	NK	ROBIDO	UX				MAR	GAR:	ET	HAND	YSIDI	Ξ
MARYLAND s retained by the hospit. 5 should be detached notified at once.	то в	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	S (Street a	nd Number or Run	/ Floute	Number, City or Town	n, State, Zip (Code)	
RE, N ay be re page 5	-	SHARON L.		RSON		P.O.	BOX	717	, BETHL	EHE	M, CT. 0	6751		
BALTIMORE, MARYI after death. Page 6 may be retained by the funeral director, page 5 should be moal.		20e. METHOD OF DISPOSIT KX Buriel 2 ☐ Cremetic	on 3 🗆 Ramo	val from Stata	20b.	PLACE AND DATE	OF DISPO	SITION (Na	nme of		DATE 20c. LO	CATION — C	ity or Town	, State
MOR age 6 ma director,		4 Donetion 5 Other		Nexe.		ARLINGT			ID ADDRESS OF			MYER	S, 1	VA
ALTIN death. Pag funeral did		ZI, SIGNATONE OF FORM	11/						ETON FU					
BAI ter dez the fu oval.		24	Kutte				G	LEN	BURNIE.	MD	21061			
S - 5 6		23. PART I. Enter the dahock, or h	liseasea, or co naart fallure. L	omplications the	t caused	the death. Do	not ente	r the mo	da of dying, au	ich aa	cardiac or reapi	ratory arre	at,	Approximate Interval Between
		IMMEDIATE CAUSE (FI		0.	1.		1	0			00			Onset and Death
tely mati		disease or condition reaulting in death)	→ "	. JAC	Ker	mic (ar	w	nyon	20	egg.			
P P P P				DUE TO	OHASA	CONSEQUENCE O	4	0	-00	0.	0			1
E 68 executand and burn	CERTIFICATION	Sequentially list condit		DUETO	(OR A5 A	CONSEQUENCE O	and	Je	way	_				-
BOX ficate be en physician a proper to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne prior to ne	SAT	If any, leading to imme cause. Enter UNDERLY	ING	Coro	ru	1 1	ili	1	der	e	-0-			1
O. B ertificat ing phy rgiene p	Ĕ	CAUSE (Disease or Injuthat Initiated aventa		DUE TO	(OR AS A	CONSEQUENCE O	7:	71						
S, P.O. E death certifica attending physiere in Hygiene iny, or other	FH	resulting in death) LAST												
ORDS, P.O. BC that the death certificate of by the attending physic in and Mental Hygiene pri any Injury, or other tr	MEDICAL	PART II. Other significa	ent conditions	contributing to	Seath by	ut not resulting	n the u	nderigin	r cause hiven I	n Part	1 240 MMS AM	ALITOREV	Î are w	EBE ALITOREY CHIDINGS
ORDS, that the dea ed by the atf mand Mentation any linguistion.		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE												
O 2 2 "		The VES 2 NO DE DEATH?												
RECON requires been sign fit, of Healt		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
AL has ber Dep	SICIAN:	25. WAS CASE REFERRED J	-	IDOTE TO CA		26. PLACE OF DEA			ONCERIA	114				
F VITA SICIAN: The certificate h the State if	SIC	EXAMINER?		HOSPITAL:	ER/Outp	ntient 3 DOA	OTHE		e 5 🗆 Residence	A. []	Other (Specify)			
F V	РНҮ	27. MANNER OF DEATH		28e. DATE OF (Month, E	INJURY	28b. TIN	E OF	28c. INJ	URY AT	7	DESCRIBE HOW II	NJURY OCCU	JRED	
ISION OF VI- KITENDING PHYSICIAN: COTOR: After this certifica after death with the St. 28 is marked, or lit.	ВУ	1 Natural 5 2 Accident	Pending Investigation	(MOINI), L	ray, rear)	, m	URY M	_	RK? (ES 2 NO					
NOING P. S. After Is death		3 Suicide 8	Could not be	28e. PLACE C	F INJURY etc. (Speci	— At home, farm,	treet, fac	tory, offic		281.	LOCATION (Street e City or Town, State)	and Number o	r Rural Rou	te Number,
DIVISION OR ATTENDING R DIMEGTOR: After hours after death item 28 is man		4 Homicide	datermined								Only of Town, State)			
D OR OR Titem			TIFYING PHYSICI	IAN: To the best of	my knowle	edge, death occurr	d at the	time, date	end place, and de	e to th	e cause(a) end men	ner as state	1.	
TO THE HOSPID TO THE PIERAL De filed within 72	COMPL	one) 2 MED	ICAL EXAMINER	On the basis of a	xamination	end/or investigation	n, In my	opinion, d	eath occured at th	e time,	data and place, en	d due to the	ceuse(e) e	nd manner ee stated.
THE HO THE PA	BE C	296 SIGNATURE AND THE	OF CENTIFIER	/	- Carol	111			29c. LICENSE N	UMBER	_ /]	29d. DATE	SIGHED	rgen payrous
은 요 요 요 요 . 나 는 를 MP C	0	forge m	116	my	M	10			1136	25	6	D /.	2/9	174
00	F	30. NAME AND ADDRESS OF	F PERSON WHO		1									V
20	1	JORGE M. 31. DATE FILED (Month, Day,	RAMIREZ				RD :	#205	/GLEN BI	JRN:	IE, MD 2	1061		
		DEC 1 3 19	994 Ja	32. REGISTRA	TRA	lall								

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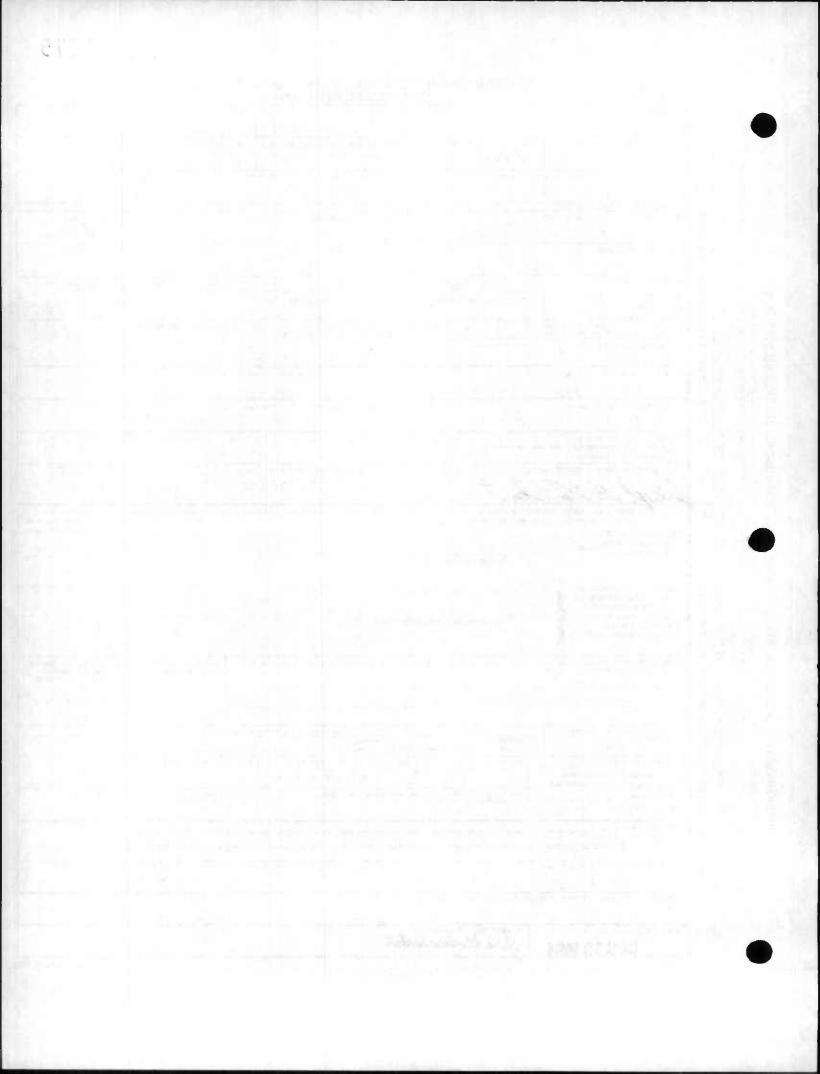
BALTIMORE, MARYLAND 21215-0020

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VISION OF VITAL RECORDS, P.O. BOX 68760	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within our ster death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burlal, certainly, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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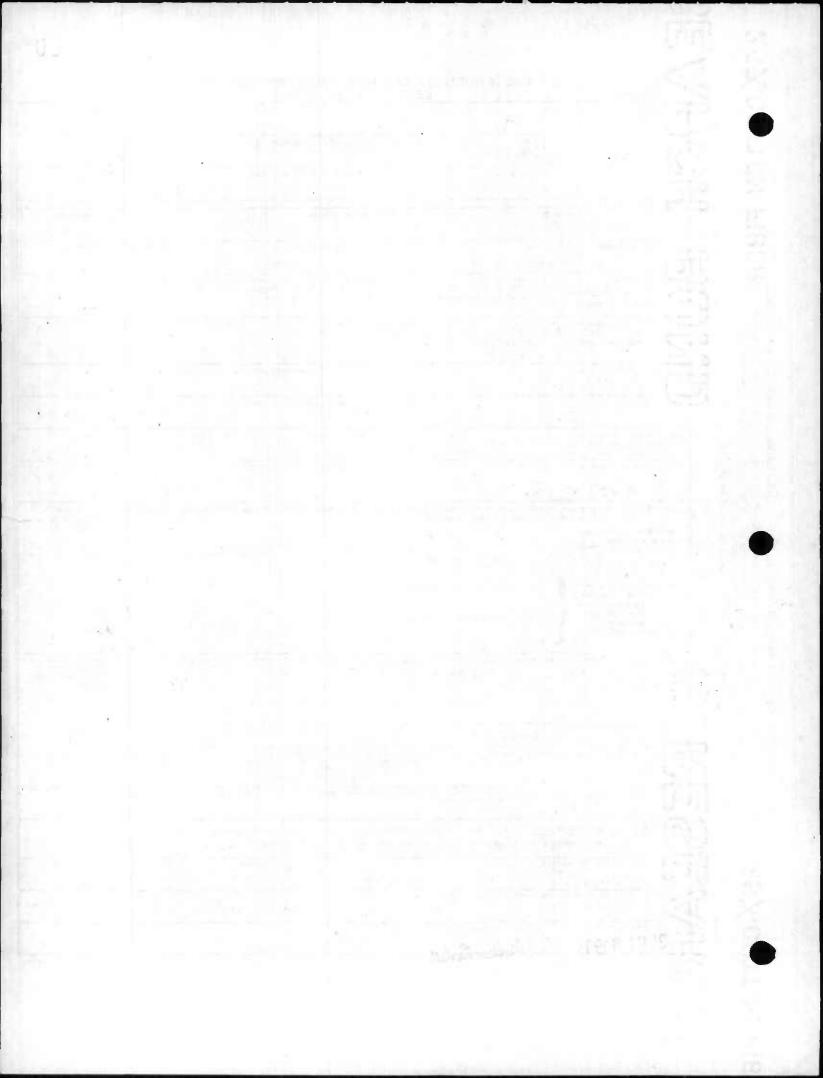
STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CERTIFICATE	OF DEAT	H		REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MA		DEPARTMEN RTIFICAT				GIENE				
1	1. DECEDENT'S NAME (First, Middle, Lest)	NANCY E	LLEN	ATKIN		NSON	2. DATE OF DE MONTH	BER 25 /	994 1750 M			
		1 🗆 M 2 🙀 F	AGE (In yrs. last t	YRS. MONTHS		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BH (Month, Day, 6-18	-22	L BIRTHPLACE (State or Foreign Country) Maryland			
TOR	PENINSULA REGIONA		CENTER		SALISI	BURY	EATH		OMICO			
DIRECTOR	Maryland Wico	omico Co	unty	10c. CITY, TOWN	or Location				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	811 Colony Dri	lve			101.	218	01	US.	A COUNTRY?			
BY	11. MARITAL STATUS 1 Never Married 2 🔣 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 NO	ED 13	If yes, spec	NDENT OF HISPA Hy Cuban, Mexico NO Specia	an, Puerto Rican,		4. RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	kind of work done to NOT use retired.	USUAL OCCUPATION ork done during most of working pretired.)									
OMP	1 2 +	2	1 7	releph	phone Operator 16. MOTHER'S NAME (First, Middle, Melden Surname)							
BE (William James 190. INFORMANT'S NAME (Type/Print)	Ho11o						tta Well				
임	Mr Joseph Atki	nson,Jr						ury, MD2				
	20a. METHOD OF DISPOSITION 1											
	21. SIGNATURE OF FUNERAL SERVICE LICES	NSEE Ronald	Wade						omy Board MD21201			
CERTIFICATION	shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CAUSE (Disease or injury that initiated events resulting in death) LAST											
MEDICAL CE	PART II. Other significant conditions CARDIAE Seizure D.	suiting in the t	underlying	cause given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
AN:	physo Hysaid											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO											
ВУ РН	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	28a. DATE OF IN. (Month, Day,		26b. TIME OF INJURY M	28c, INJU WOR 1 YI	RY AT K? ES 2 NO	28d. DESCRIBI	URED				
	3 Suicide 6 Could not be 4 Homicide detarmined	ictory, office		261, LOCATION City or Tow	ION (Street and Number or Rural Route Number, Town, State)							
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:								i. cause(a) and menner sa stated.			
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	MO				29c. LICENSE NU 039	813		SIGNED (Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO MY ATT KINS	MO	0104	Reall	Thuras	Due	SAU	S MD	21801			
	31. DATE FILED (Month, Day, Year) DEC 13 1994	32. REGISTRAR'S	SIGNATURE P	rhall								



OHMH-16 Rev 1/89

- 1	1 - STATE REGISTRAR	SIAIE UF MARY	LAND / DEPART CERTIFIC			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Α.	ATV	IEL	1	2. DATE OF DEATH	94	OFOO	
	4. SOCIAL SECURITY NUMBER 22-0-30-50-5 9a. FACILITY NAME (If not institution, give	1 □ MX X F	88 YRS.	IF UNDER I YEAR	IF UNDER 24 HMS. HOURS MIN. OR LOCATION OF DEAT	7. DATE OF BIRTH (Morith, Day, Year) 02-26-06	MAF	ACE (State or Foreign	
СТОВ		PITAL			LTIMORE	CITY	c. COUNTY OF DEA	TH	
DIREC	MARYLAND 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCA	LTIMORE	CITY		Dd. INSIDE CITY LIMITS? YES 2 \(\) NO	
VERAL		BOND STRE	ET	10	21231	10	U.S.		
BY FUN	11. MARITAL STATUS XV Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	es ax Xno	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Ricen, etc.) 1 YES NO Specify: Specify					
COMPLETED	15. DECEOENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+) YEARS	18a. DECEDENT'S U (Give kind of wo life. Do NOT use REGEST!	L UESTMII OSDD					
ш	17. FATHER'S NAME (First, Middle, Last) JOHN FRANCIS	S ATWELL	18. MOTHER'S NAME (First, Middle, Malden Surname) EMMA KIRCHNER						
TO B	19a. INFORMANT'S NAME (Type/Print) LISABETH L.	CATES				ute Number, City or Town, St REET, BALT		ID.2123	
	20s. METHOD OF DISPOSITION 1								
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute	Palmè	saly			ory arrest,	Approximate Interval Bett Onset and I	
ERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL C	PART II. Other algorificant condition	ns contributing to death	the underlyin	ng couse given in Pr	24a. WAS AN AUT PERFORMED 1 YES XX	NO O	TERE AUTOPSY FIND WAILABLE PRIOR TO OMPLETION OF CAU F DEATH? YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES XIXNO 26. PLACE OF DEATH (Check only one) OTHER: A Universing Home 5 Residence 8 Other (Specify)								
BY PHYSICI	27. MANNER OF DEATH 1- Netural 5 Pending 2 Accident Investigation	28a. OATE OF INJUR (Month, Day, Year	Y 28b. TIME	OF 28c. IN	8 Other (Specify) 28d. OESCRIBE HOW INJURY OCCUREO				
ED	3 Suicide 6 Could not be 4 Homicide determined	IRY — At home, farm, str (pecify)	At home, farm, street, factory, office 28t, LOCATION (Street and Number or Bural Boute Number						
COMPLET		SICIAN: To the best of my kn ER: On the bests of examine						nd manner as stat	
9						-			
TO BE CC	296. SIGNATURE AND TITLE OF CERTIFIE	Red.	Enecial	ist	29c. LICENSE NUMB	356	A DATE SIGNED (M	fonth, Day, Year)	



BALTIMORE, MARYLAND 21215-0020

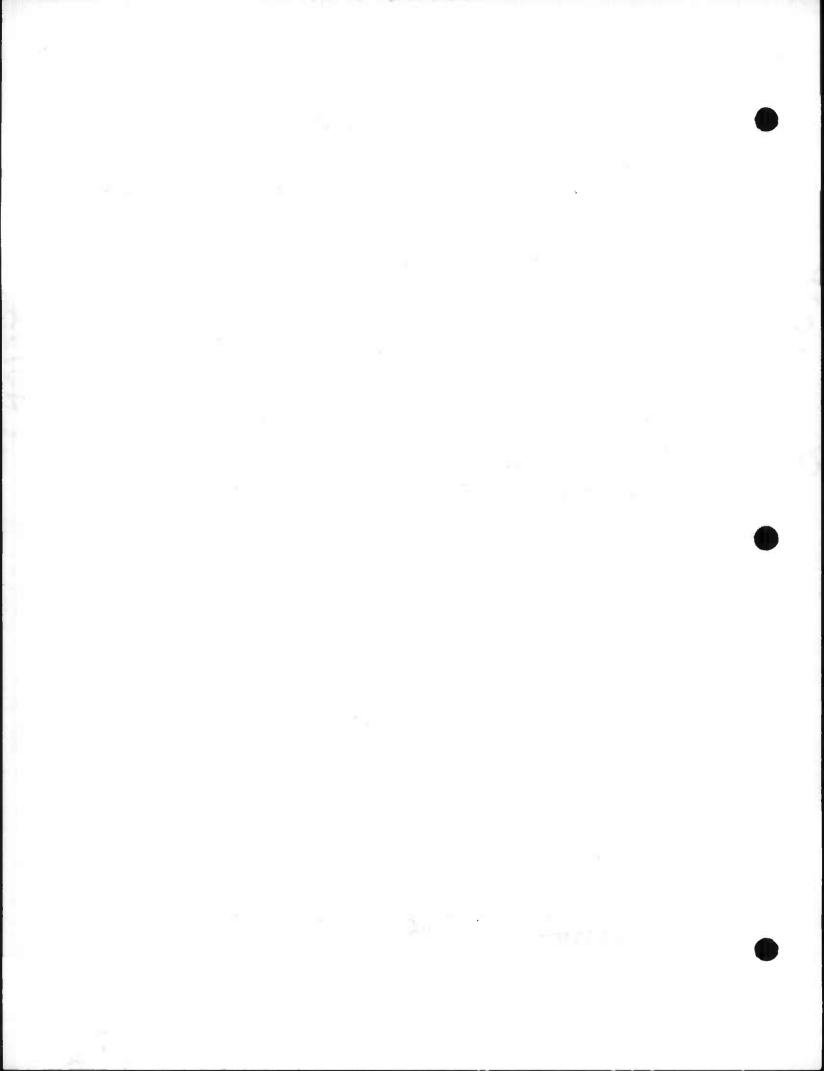
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

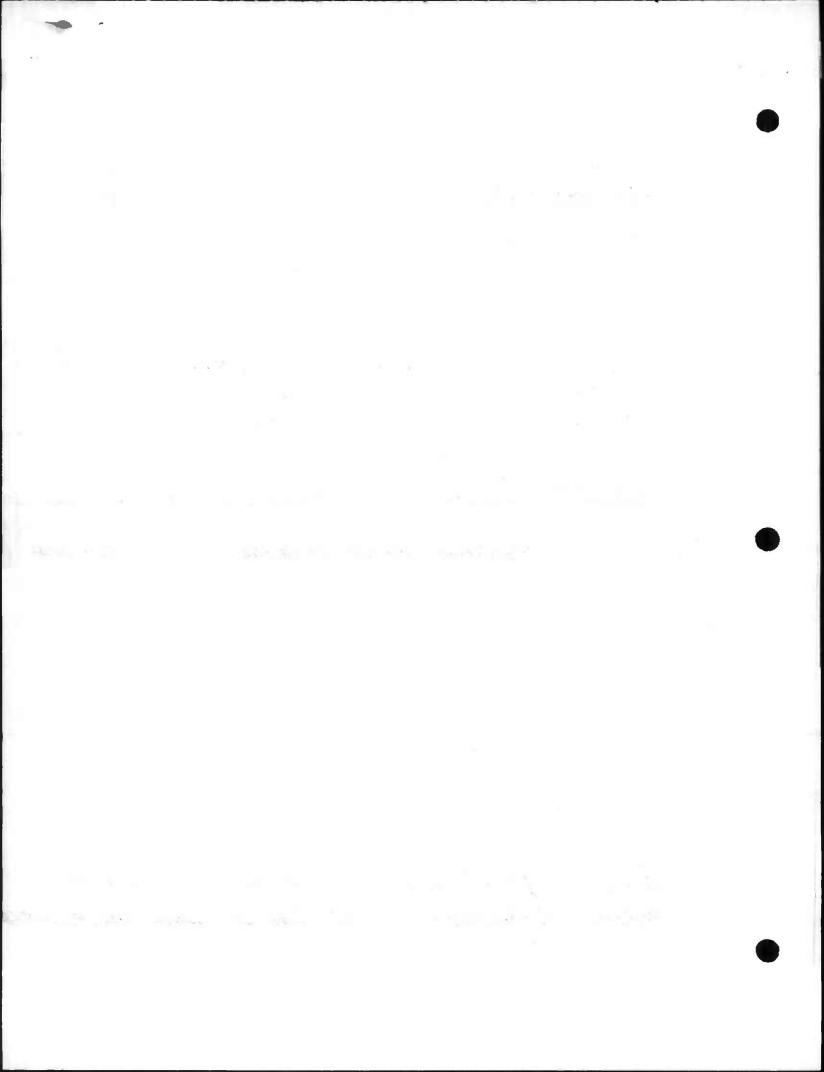
	REGISTRAR				F DEATH	711	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH		3. TIME OF DEATH		
1	LENORE	ELIZABETH		AUK	ER	NOVEMB	ER 30,	1994	02:05 Am		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF B		_	IPLACE (State or Foreign		
- 3	212 38 5606	t 🗆 M 2 🕞 F	87 yas.	MONTHS DAY	'S HOURS MIN.	(Month, Day	Year)	Countr	(Y)		
	9e. FACILITY NAME (If not institution, give a	**	07	a. a.m		6-15-			yland		
m					N OR LOCATION OF D	DUNTY OF D					
<u>ē</u>	SACRED HEART HOS	PITAL		CUMBERLAND			ALLEGANY				
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	v	140-013	Y, TOWN OR LO	017/01/						
<u>E</u>					CATION		10d. INSIDE CITY LIMITS?				
-1	Maryland Alle	gany Count	<u> </u>					t YES 2 N			
₹	100. STREET AND NUMBER	D			101. ZIP CODE		10g. C	10g. CITIZEN OF WNAT COUNTRY?			
监	112 Forest	Drive-Suns	set View		21	502		Ţ	USA		
FUNERAL	1t. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. ARMED	13. WAS DECENDENT OF NISPANIC ORIGIN? (Speci				14. RACE	E — American Indian, k, White, etc.		
	t Never Merried 2 Merried	FORCES? t YE	DATES		specify Cuben, Mexica YES 2 NO Specific		etc.)				
B	3 A Widowed 4 Divorced		No.	' ''	LO 2 NO Space	·y.		Speci	"Y: White		
COMPLETED	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OCCUPA	ATION	16b, KINI	OF BUSINESS/	NDUSTRY			
<u>L</u>	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during se retired.)	most of working	77.4		_			
4	12+	E	Teache	r		Eu	ucatio	11			
8	17. FATHER'S NAME (First, Middle, Last)										
	John George K	vlus			Ann	Grable)			
BE		,									
2	t9e. INFORMANT'S NAME (Type/Print)				et and Number or Rural			Zip Code)			
	William W. Res	sser	POBo	x 6/,	Pinto,M	D21556)				
	20e. METNOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem		ob. PLACE AND DATE		(Neme of	DATE	20c. LOCATION	— City or To	wn, State		
!	4 to Donetton 5 - Other (Specify)			,							
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEERonald	Wade, Di	22. NAME	AND ADDRESS OF FA	CILITY Sta	te Ana	tomy	Board		
	100	-	5	655	W.Baltin	more S	t.Balt	o MD	21201		
	court to les	~ sens		Do not enter the mode of dying, such as cardiac or respiretory streat, Approxi							
	ahock, or heart failure.	List only one cause on	ed the death. Do i	not entar tha	mode of dying, suc	ch ss cardiac	or respiretory	irraat,	Approximata interval Batween		
	IMMEDIATE CAUSE (Final	W. D. A. A. Sandari							Onset and Dasth		
	disesse or condition reaulting in death)	a. Chronic of	The deep	Lung	Auguse						
		DUE TO (OR AS	A CONSEQUENCE O	F):	La Cy Cy						
z											
9	Sequantisity list conditions, if any, laading to immediate	DUE TO (OR AS	S A CONSEQUENCE OF	F):							
Z I	cause. Enter UNDERLYING	_									
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):							
F 1	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in desth) LAST										
C											
CER		d									
AL CER	PART II. Other significant condition			1			WAS AN AUTOPS	Y 24b.	. WERE AUTOPSY FINDINGS		
ICAL CER	PART II. Other algorificant condition Hywerenegar			1			PERFORMED?	Y 24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
IEDICAL CERTIFICATION	11.0			1				Y 24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ	Hyperlenger	· Div	estralos	w use	Sogerardo	' [PERFORMED?	Y 24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
Σ	Hyperlenger DID TOBACCO USE CONTI	· Div	OF DEATH YE	w Me	Deferverelle UNCERTAIL	' [PERFORMED?	Y 24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YE	w Me	Deferverelle UNCERTAIL	' [PERFORMED?	Y 24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ	DID TOBACCO USE CONTI	RIBUTE TO CAUSE HOSPITAL: 1/2 Inpatient 2 = ER/On	OF DEATH YE 26. PLACE OF DEAT utpattern 3 □ DOA	S DONO TH Check only or OTHER: 4 Nursing N	UNCERTAIL	N 🔲	PERFORMED?	Y 24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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DIVISION OF VITAL BECORDS P.O.

- 1	1. DECEDENT'S NAME (First, Middle, Last,)	CERTI				OF DEATH			3. TIME OF DE	ATH
	GEORGE ALFRED	BAILEY				Dece	ember .	AY 5. 199	YEAR Q/i	5:36	ъ
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthda		IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	IPLACE (State or	
	222-12-4101		74 YRS.	MONTHS DAYS	HOURS MIN.		th, Day, Year)	920	Countr	w rginia	
~	9a. FACILITY NAME (If not institution, give		-	9b. CITY, TOWN	OR LOCATION OF D			9c. COUN			
CTOR	ATLANTIC GENERAL	HOSPITAL		BERL	IN			WORG	CEST	ER	
JEC.	10a. STATE 10b. COUN	TY	10c. C	ITY, TOWN OR LOCA	ATION					10d. INSIDE C	TY
DIRE	Delaware Si	ussex		Selbyvi	11e					LIMITS?	_ NC
ERAL	10e. STREET AND NUMBER	Of. ZIP CODE						?			
NE NE	21 Hoosier Stre	19975	UDA								
FUN	11. MARITAL STATUS 1 Never Married 2 Narried	CENDENT OF HISPA pecify Cuban, Maxic	NIC ORIGI In, Punto	N? (Specify Yes Rican, etc.)	s or No-	14. RACE Black	E — American Ir k, Whila, atc.	dlan,			
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗆 YE	S 2 NO Specif	y:	, Puarto Hican, etc.) Sp			⊮y: Blac	·le
8	15. DECEDENT'S ED	UCATION		DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					DIA	- 1	
LETI	Elamentary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	f work done during m use retired.)	nost of working						
COMPL	8		Chick	en Catch	er	E	oultry	Indu	ıstr	v	
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA						
BE	Horace Bailey 19a. INFORMANT'S NAME (Type/Print)		1		Maggie		ens				
2	Virginia Townsen	.1			and Number or Rural					_	
	20a. METHOD OF DISPOSITION			BOX 52/	, Selbyvi	.lle,		Tare 1			_
	XIX Burial 2 Cremation 3 Rar 4 Donation 5 Other (Specify)	movel from State CR	metery cremetory of	other plecel	Cemetery	1					
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE /	ar Gord	22. NAME A	AND ADDRESS OF FA	CITY	IU BIS	nopvi	TTE	. Mary	ar
	10-11-	/									
	IMMEDIATE CAUSE (Final	complications that cause on a	od the death. Do	211 7	on Funera Washingto ode of dying, aud	1 Ho	Mil	1shor	o]	Delawar Approxi Interval Onset a	met Bet
TIFICATION	ahock, or heart failure.	a. CORON/FIR DUE TO (OR AS DUE TO (OR AS	each line.	211 To not enter the moore, of the control of the c	Mashingto ode of dying, aud	1 Ho on St haacar	Mil	1shor	eat,	Approxi	mate Bets nd [
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AL CERTIFI	anock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. CORONAR DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE A CONSEQUENCE	211 To not enter the moof): OF): OF):	Washingto	1 Ho on St haacar	Mil	1sbor fratory arre	eat,	Approxi Interval Onset a Sew 30	FIND R TO
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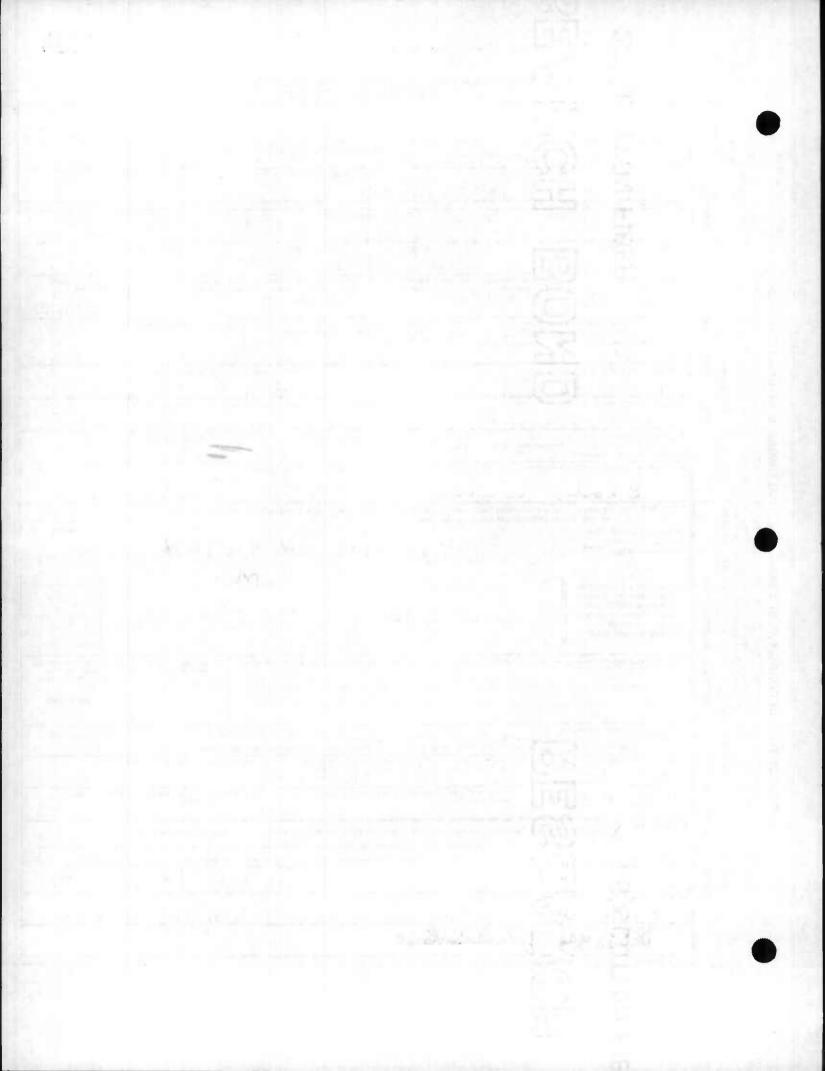


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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 show	
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	1 - STATE REGISTRAR) / DEPARTMENT CERTIFICATE		MENTAL HYGIENE REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)	-> .0 0 .			2. DATE OF DEATH		3. TIME OF DEATH			
	HARRY	O BAI	KER		MONTH DAY		8-21 PM			
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs.		YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. BIFTT	HPLACE (State or Foreign			
	214-03-4031	12□F 86	YRS.		March 30. 190		ryland			
l ~	9a. FACILITY NAME (If not institution, give street and			OWN OR LOCATION OF DE		9c. COUNTY OF E	DEATH			
DIRECTOR	RESIDENCE OF DECEDENT	op. S.T.	4 130	ellimore	Celia	Baltim	ore City			
) ñ	10a, STATE 10b, COUNTY		10c. CITY, TOWN OR	LOCATION	<i>i</i> /		10d. INSIDE CITY			
5	Maryland Carroll	County	Marri	ottsville			LIMITS?			
AL AL	10a. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNERAL	7441 Brangles Road			21104		U.S.	Α.			
Ē	11. MARITAL STATUS 1 Never Merried 2 Merried FOI	DECEDENT EVER IN U.S.		S DECENDENT OF HISPAN	IC ORIGIN? (Specify Yee	or No — 14. RAC	E — American Indian, k, White, etc.			
BY	II I I I I I I I I I I I I I I I I I I	ES, GIVE WAR OR DATES		YES 2 NO Specify	:	Spec				
0	15. DECEDENT'S EDUCATION	16a.	DECEDENT'S USUAL OCC	IPATION	16b. KIND OF BUS	INECC/INDUCTOR	WIIICO			
	Elementary/Secondary (9-12) College	d) e (1-4 or 5+)	(Give kind of work done dur life. Do NOT use retired.)	ing most of working	Job. KIND OF BOS	INESS/INDOSTRI				
7	8	(1.4.6.2.1)	Linem	an	Teleph	none Com	pany			
9 0	17. FATHER'S NAME (First, Middle, Last)	Sumame)								
BE at	John Wesley Bal									
1 P	198. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7441 Brangles Road Marriottsville, MD 21104							
9	Mrs. Sylvia Baker									
nust	1 Description 5 Other (Specify)	state cemetery.	crematory or other place) View Mem.		13/94 Syl					
Je.	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	/		ME AND ADDRESS OF FAC		Kesville	, 110			
examiner must be notified at once. TO BE COM	Drige of	Milst	B	AIGHT FUNE						
	23. PART I. Enter the diseases, or complications	tions that raised the	death Do not enter th	Sykesville,						
medica	snock, or neart isliure. List onl	y one cause on each i	line.	e mode of dying, such	as cardisc or reapir	atory strest,	Approximsta interval Between			
흝	iMMEDIATE CAUSE (Final disease or condition	APDIO	RECD. 00	100V 1	200505		Onsat and Desth			
event,	resulting in death)	DUE TO (OR AS A CON	RESPIRA	FIDRY	TRKES)	a War				
	Convention, the condition of b.	NOXIC	HEAD SEQUENCE OF):	TNTI	IRY	Was BI	ļ			
traumatic ATION	Sequentially list conditions, If sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CON	SEQUENCE OF): O INTRAVENTR	37730	Done	No. of the last				
other tr	CAUSE (Disease or injury	BURAL AND	SEQUENCE OF:	ICUCAR HENIO	RRHAGE					
y, or other traumatic	that initiated events resulting in death) LAST				All Andrews					
	DART II Other step Massa and distance and									
K Ingu	PART II. Other significant conditions contri	buting to death but no	ot resulting in the unde	rlying cause given in i	Part I. 24a. WAS AN A PERFORM		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
shows any : MEDIC					1 YES 2	NO	OF DEATH?			
ğ Z	DID TOD ACCO LICE CONTRIBUTE	TO CALLET OF D	FATURE TO A				1 VES 2 NO			
AN	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL		LACE OF DEATH (Check only							
PHYSICIAN:		PITAL:	OTHER:	g Home 5 Residence						
H.		DATE OF INJURY	26b. TIME OF 25	C. INJURY AT	28d. DESCRUBE HOW IN	JURY OCCURED				
marked, BY PH	1 Netural 5 Pending 2 Paccident Investigation	(Month, Day, Year)	2200 PM	WORK?	Dubrico	t Fel	L			
	3 Suicide 6 Could not be	PLACE OF INJURY — At building, atc. (Specify)	home, farm, atreet, tectory	, office	28f. LOCATION (Street an City or Town State)	nd Number or Rural I	Route Number,			
	4 Homicide detarmined		Home		7441 Bri	andi	Rd.			
COMPLETED	29a. CERTIFIER (Check only one) PHYSICIAN: To									
5 8	2 MEDICAL EXAMINER: On the	basis of examination and/	or investigation, in my opin	ilon, death occured at the t	time, date and place, end	due to the ceuse(e	e) end manner ee ateted.			
BE COMPLE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM	BER	29d. DATE SIGNED	- 10			
2	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CALIFE OF DEATH	TEM OR OTHER STATE			15/0	9194			
	SHOCK TRAVMA	ENTER .	22 SOUTH	GREENE	ST. BALT	IMORE,	MD 20201			
	DEC 1 3 1994	REGISTRAR'S SIGNATURE	E							

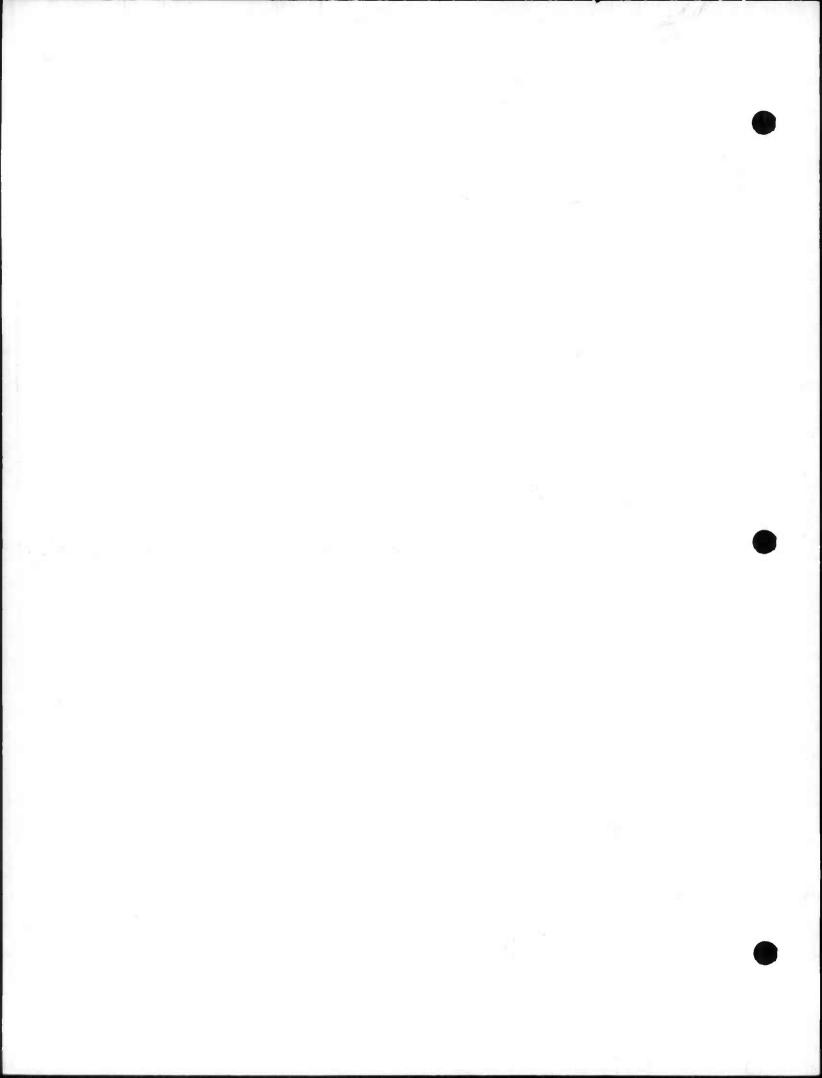
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	1. DECEDENT'S NAME (First, Middle, Last	WILLIAM	Ho	BALD.	WINSE	2. DATE OF DEATH	DAY 100	3. TIME OF DEAT		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	10-0	BIRTHPLACE (State or For		
	9a. FACILITY NAME (If not institution, give	1 1 M 2 F	76 YRS.		OR LOCATION OF DE	7-13-1	9/8	V, C,		
СТОВ	Northwest A	redical C	enter	Ran	dallsto	wn		TOT DEATH		
DIREC	10a. STATE 10b. COUN	ITY	10c, CI1	TY, TOWN OR LOCA	TION		10d. INSIDE CITY			
	10e. STREET AND NUMBER			alto	f. ZIP CODE		1) YES 2 -			
FUNERAL	4212 Fer	nhill Au	1 Ave 21215				10g. GIIZEN O			
BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	If yes, so		IIC ORIGIN? (Specify Yon, Puarto Rican, atc.)				
ETED	15. DECEDENT'S ED (Specify only highest gra-	OUCATION de completed) College (1-4 or 8 +)	16a. DECEDENT'S (Give kind of life. Do NOT u	Work done during muse retired.)	ON ost of working	16b. KIND OF BU	JSINESS/INDU	STRY		
COMPL	12th	Conege (1% or a +)		Tool 00	erato.	U	S. Co	pastal Gua		
	17. FATHER'S NAME (First, Middle, Last)	1dws			18. MOTHER'S NA	ME (First, Middle, Meide	n Sumame)			
2 Sie Baldwin 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip										
	20a. METHOD OF DISPOSITION		Ob. PLACE AND DATE		nhill f	OATE 20c. Je	OCATION -, CI	Hy or Jown, State		
	1 Buriel 2 Cremetion 3 Re 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE I		emeter, crematory or o	7500 tul	rest Vet	12-15-94	Vings	Hills, Md		
	DI COLDENS SERVICE	LICENSEE CO. O. O. O.		Yar.	ND ADDRESS OF FA	. Wast	10	B- 14.		
	23. PART I. Enter the diseases, or shock, or heart failure	r complications that cause. List only one cause on	ed the death. Do	not enter the mo	ode of dying, suc	h as cardlec or real	piratory arre	at, Approxima		
	IMMEDIATE CAUSE (Final disease or condition	M	MACAD	DIAL	TNE	APATIA	201	Onset and		
	resulting in death)	DUE TO OR AS	A PONSEQUENCE O	VIAL	1/1/	ARCTIC	NA			
NO		b. DUE TO OR AS	JLMON	JARY	EDE	MA	J/V			
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	PI PI	LMON B A CONSEQUENCE O		EDE	MA	DIN			
NIFICATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR AS		TE C	EDE	MA	DIN .			
CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS	ROSTA B A CONSEQUENCE O	TE C	EDE	MA R.				
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BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YNO 27. MANNER OF DEATH 1 Netural 5 Pending	DUE TO (OR AS c. DUE TO (OR AS d	CROSTA B A CONSEQUENCE Of the consequence of the c	26. P OTHER: ME OF JURY M 1	ANCE ANCE In g cause given in LACE OF DEATH (Ch	Part I. 24a, WAS AL PERFC 1 YES	N AUTOPSY PRIMED? 2 NO INJURY OCCU	AMALABLE PRIOR COMPLETION OF COP DEATH? 1 YES 2 N		
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COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are sufficient conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigations are sufficient conditions. Pending investigations are sufficient conditions. Pending investigations are sufficient conditions. Pending investigations are sufficient conditions.	DUE TO (OR AS c. DUE TO (OR AS d. DUE TO (OR A	ROSTA A CONSEQUENCE Of the property of the pr	26. P OTHER: 4 Nursing Hor ME OF 28c. IN. JURY M 1 Street, factory, officered at the time, date	EDE A NCE Ig cause given in LACE OF DEATH (Ch ne 5	Part I. 24a, WAS AI PERFO 1 YES eck only one) 8 Other (Specify) 26d. DESCRIBE HOW City or Town, State to the cause(a) end me time, data and place, a	N AUTOPSY PRIMED? 2 NO INJURY OCCU I and Number o	AMARABLE PRIOR I COMPLETION OF C OF DEATH? 1 YES 2 N JRED PRUIS Route Number, d. Cause(a) and manner as st		
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COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are sufficient conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigations are sufficient conditions. Pending investigations are sufficient conditions. Pending investigations are sufficient conditions. Pending investigations are sufficient conditions.	DUE TO (OR AS c. DUE TO (OR AS d	ROSTA B A CONSEQUENCE Of the consequence of the co	26. P OTHER: 4 Nursing Hor ME OF 28c. IN JURY M 1 Street, factory, office on, in my opinion, in D e, Print)	EDE A NCE Ig cause given in LACE OF DEATH (Ch ne 5	Part I. 24a, WAS AL PERFC 1 YES eck only one) a Other (Specify) 26d. DESCRIBE HOW 26f. LOCATION (Street City or Town, State to the cause(a) end multime, data and place, a MBER	N AUTOPSY PRIMED? 2 [NO INJURY OCCU I and Number of p) enner as stated and due to the	AMALABLE PRIOR COMPLETION OF COMPLETION OF COF DEATH? 1 YES 2 N PRED PRED Reveal Route Number, d. Cause(a) and manner as st		



OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
he law requires that the death certificate be executed with	PATENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.
has been signed by the attending physician and completely fille	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should
Dept. of Health and Mental Hygiene prior to burial, cremation.	1. or removal.
n 23 shows any injury, or other traumatic event, the	medical examiner must be notified at once.
	THE HIGH TALL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with thours after death. Page 6 may be retained by the host the first market at the control of the control

	1 - FOR STATE REGISTRAR	OF MARYLAND	/ DEPARTM			MENTAL	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEATH	
	MARJORI	E A	D	EALL	n	MONTH	4 4		YEAR		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs.		MOER 1 YEAR	IF UNDER 24 HRS.	DEC.	10,	1994	BIRTHE	PLACE (State or Foreign	
		me l	YRS. MON		HOURS MIN.		Day, Ybar)		Country)	"
	213-12-3845 9a. FACILITY NAME (If not institution, give street and num	A / / 9	2.00			Mar	<u>ch 13</u>			Maryla	nd
-	8399 Forest Drive	D0f)	9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNT			. 1
9	Design to the order of the property of the pro			Pas	adena			A:	nne	Arunde	1
다. 	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		100 CITY TO	WN OR LOCAT	ION					10d, INSIDE CITY	
DIRECTOR		3-1							LIMITS?		
	Maryland Anne Arun	del	P	<u>asade</u>					_	1 TYES 2 NO	
₹				100	ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?	
	8399 Forest Drive			2	1122			Unite	ed	States	
FUNERAL	11. MARITAL STATUS 12. WAS DE	S? 1 YES 2	ARMED		ENDENT OF HISPAN			or No— 14	I. RACE	- American Indian, White, stc.	\neg
B	1 Never Married 2 X Married IF YES,	GIVE WAR OR DATES	-X	1 YES			ncari, arc.)		Specify	F 71 1 .	e l
								1			
Ш	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a.	(Give kind of work of	tione during mos		16b.	KIND OF BUS	SINESS/INDUS	STRY		
Ш	Elementary/Secondary (0-12) College (1-	4 or 5 +)	Me. Do NOT use reti	red.)							- 1
F	8 -	Se	amstre	SS			omfv	Manu	fac	turing (cal
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, M	liddle, Maiden	Sumame)			
BE (Edward	M •	Beyer		Elnore	3		В	ray	den	- 1
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street a	nd Number or Rural F	Route Numb	er, City or Town				
2	Mr. Leo W. Beall,	Sr.	8399 F	orest	Drive	Pasa	adena	, MD		21122	- 1
	20a, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Removal from St	20b. PLAC						CATION — CH	_		\dashv
	1 X Burtal 2 Cremation 3 Removal from St 4 Donation 5 Other (Specify)		ACE AND DATE OF DISPOSITION (Name of y, crematory or other piece) en Haven Mem. Park 12/14/94								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	71 616	II have	22. NAME AN	D ADDRESS OF FA	CILITY	14/94	(716	2n	Burnie,	MD
l		1/	Mc Cully Funeral Ho					me of Pasadena			- 1
- 1	Valence & Klyhn	ik	3204 Mountain Rd. P					asadena, MD. 2112			121
	23. PART i. Enter the diseases, or complication ehock, or beart failure. List only o	ne thet csused the	deeth. Do not e	nter the mo	de of dying, suci	h ss csrd	lac or respl	raiory arres	it,	Approximate	
	IMMEDIATE CAUSE (Finsi									Interval Betw Onset and De	
	disesse or condition	Fire	Car	20~	non	-50	.11	11 +	00	F	
ı	resulting in desth) s	DUE TO (OR AS A CON	SEOUENCE OF):) 11011	200	TOWN LA	1	1	PMOS	
z		3						ı			
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate	DUE TO (OR AS A CON	SEOUENCE OF):								
₹	cause. Enter UNDERLYING										1
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON	SEOUENCE OF):								
	resulting in death) LAST										- 1
3	G										_
F	PART ii. Other significant conditions contribute	ing to deeth but no	ot recuiting in th	e underlying	ceuse given in	Part i.	24a. WAS AN PERFOR			WERE AUTOPSY FINDI	NGS
3							1 YES 2			COMPLETION OF CAUS	SE
ᆲᆘ						_	1 123 2	1.10		OF DEATH?	
PHYSICIAN: MEDIC						-				1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL			20 01	ACE OF DEATH (Chi	201 201 200	-1				
5	EXAMINER? HOSPIT			HER:	1/						-
2		ent 2 ER/Outpatient	_	Nursing Hom							_
		ATE OF INJURY Nonth, Day, Year)	28b. TIME OF INJURY	28c. INJI	RK?	28d. DEŞ	CRIBE HOW I	NJURY OCCU	RED		- 1
2	2 Accident Investigation				ES 2 NO						
	3 Suicide 8 Could not be 4 Homicide detarmined	LACE OF INJURY — At uliding, atc. (Specify)	home, larm, street	, lactory, office	'		ATION (Street a or Town, State)	and Number or	Rural Ac	oute Number,	- 1
2	29a. CERTIFIER Check only 1 CERTIFYING PHYSICIAN: To the	best of my knowledge,	death occurred at	lhe lime, data	and place, and due	to the cau	se(s) and mar	ner as stated			
COMPLETED	one) 2 MEDICAL EXAMINER: On the be	als of axamination and/	or investigation, in	my opinion, de	eath occured at the	time, data	and placa, an	d dua lo the	cause(a)	and manner as state	d.
- 41	299. SIGNATURE AND TITLE OF CERTIFIER	$-\rho$	-	T	29c. LICENSE NUN	men		294. DATE 5	CHINGS:	Moren day mary	\dashv
岁(KIN ODO DO	7	m	- 1	MZ	176		> /	17	1/04	- 1
إ ⊆	35-AME AND ADDRESS OF PERSON WHO COMPLETE	ED ALISE OF DEATH (75.107.00		1/2	1)3	, /		71	477	_
	10000	M A	I / M A	· C ^	())	. (1	1110	la b	(11	, , ,
	anssell al. Jela	ea /111.	600	>-(19in F	ngh	tal for	400	(H)	MY CHAIL	16/
	DEC1 3 1994 July 2016	GISTRAR'S SIGNATURI	E '			1	1'	,		,	
	DECT 9 1994 Junt 21	nator stores									
			2							DHMH-16 Re	100



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

THE HISPALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an ours after death. Page 6 may be retained by the hospital or attending physician.

THE FIGHAL OFFICIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be marked to a start of the after and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	FICATE OF	DEATH	REG. I	NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH		
	AUGUST	P	BISESI			DEC.	7, 19	YEAR	M		
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1, 19:		HPLACE (State or Foreign		
	220-18-2627	1X M 2 🗆 F 6		MONTHS DAYS	HOURS MIN.	Month, Day, Year, Dec. 26,	1925	Count	yland		
	9e. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN	OR LOCATION OF O	EATH	9c. COL	9c. COUNTY OF OEATH			
DIRECTOR	7730 West Drive			Glen	Burnie		Anne	e Arı	undel		
5	RESIDENCE OF DECEDENT										
2	10s. STATE 10b. COUNTY		10c, CI	TY, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?		
	Maryland Anne	Arundel		Glen Rurnie							
A	10a. STREET AND NUMBER			101. ZIP COOE			10g. CIT	TIZEN OF	WHAT COUNTRY?		
15	7730 West Drive				21060	United			Thatas		
FUNERAL		2. WAS DECEDENT EVER		13. WAS DE	NIC ORIGIN? (Specify	Yes or No-	E American Indian,				
	1 Never Married 2 X Merried	FORCES? 1 YES	2 NO		pecify Cuban, Mexica S 2 X NO Specif	in, Puerto Rican, etc.)		Spec	k, White, etc.		
BY	3 Widowed 4 Divorced	WW	2		- Q1	,.		-	White		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION projeted)	16a. DECEDENT	S USUAL OCCUPAT	ON	16b. KIND OF	BUSINESS/IN	DUSTRY			
		College (1-4 or 5+)	Itle. Do NOT	work done during muse retired.)	osi or working						
릴	6		Chauf	For		Palto	way Div				
0	17. FATNER'S NAME (First, Middle, Last)		Chadi		16. MOTHER'S NA	ME (First, Middle, Maid	den Surname)	argi	May IIIV		
	John A.	Bisesi			Marie	M	Pond	3			
BE	19a. INFORMANT'S NAME (Type/Print)	DIBOBI	19b. MAILIN	G ADDRESS (Street		M . Boady oute Number, City or Town, State, Zip Code)					
일	Mrs. Doris V. Bise	ci									
	20a. METHOD OF DISPOSITION			7730 West Drive Glen Burnie, MD. 21060							
1 1	1√ Buriel 2 ☐ Cremetion 3 ☐ Remove	al from State	b. PLACE AND DATE metery, cremetory or	other plecel			LOCATION -				
	21. SIGNATURE OF FUNERAL SETTING LICES		<u>len Haver</u>	n Memoria	al Park 1	2/10/94	Glen	Burr	nie, MD.		
	21. SIGNATURE OF FUNERAL SENGRE LICES	20 11			NO ADDRESS OF FA		- F D				
	7/10 1 17	Din il		13204 I	ily runer	al Home o	or Pas	ader	na na na na		
	23. PART I. Enter the diseases, or co	mplications that cause	d the death. Do	not enter the m	ode of dying suc	RQ. Pas	adena.	MD.	21122		
1 1	shock, og heart fallure. Li	st only one cause on	eech line.	THE CITE THE THE	ode of dying, suc	in as cardiac or re	apiratory at	rest,	Interval Between		
1 1	IMMEDIATE CAUSE (Fine)	V.							Onset end Death		
	resulting in deeth)	netrola	tic lun	coma					13 months		
		OUE TO (OR AS	A CONSEQUENCE	OF):							
Z	Sequentially list conditions, b.										
CERTIFICATION	if any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE	OF):							
2	CAUSE (Disease or Injury										
발	that initiated events	OUE TO (OR AS	A CONSEQUENCE	OF):							
E	resulting in death) LAST										
	PART II. Other algnificant conditions	contributing to death	but not requising	In the underlyis	a seuse abres la	Don't law was	AN AUTOPSY		b. WERE AUTOPSY FINDINGS		
DICAL	3000	oonling to double	Dut not resulting	in the underlying	ig cause given in		FORMED?	/ 241	AVAILABLE PRIOR TO		
				·		1 YES	2 1 NO		OF DEATH?		
M									1 TYES 2 NO		
z l											
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	1005			LACE OF DEATH (Ch	eck only one)					
Si		HOSPITAL:	tpetient 3 DOA	OTHER:	ne 5 Raeldence	6 Other (Specify)					
<u> </u>	27. MANNER OF OEATH	26e. DATE OF INJURY	28b. TI		JURY AT ORK?	28d. OESCRIBE HO	W INJURY OC	CURED			
	1 Natural 5 Pending	(Month, Day, Year)	- 10		ORK? YES 2 NO						
BY	2 Accident Investigation 3 Suicide & Could get be	280. PLACE OF INJUR	Y — At home form			281, LOCATION (Stre	at and Mush		Courte Misselve		
	4 Nomicide 8 Could not be	building, atc. (Spi	ecify)	acrost, tactory, on		City or Town, St	ato)	or nurar	House Number,		
	AA- AFFERING										
릴		AN: To the best of my know									
COMPLETED	2 MEDICAL EXAMINER:	On the basis of examinati	on and/or investigat	ion, in my opinion,	death occured at the	1ime, data end place	, end dua to t	he cause(e) end manner ee stated.		
L w	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DA	TE SIGNE	(Month, Day, Year)		
00	An Ottom	MD			2408		•		8/14		
임	30. NAME AND ADDRESS OF PERSON WHO	-	EATN (ITEM 27) / Tun	e. Print)	27000			1 "	- 17		
	YVONNE OTTAVI				A1 T1 44 -0	NE MIN	2.12	20			
ч (TIVE, D	ALIMO	1-4		7			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG						,			
	DEC1 3 1994 A	la d'avoler Re	volalle								

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 22. PER F.H. FILM G-718 12/13/94 FOR STATE STATE OF MARYLAND STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIFI	CATE OF	DEATH	F	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	NABELLE		RI	ACKER	+	2. DATE OF MONTH	DAY	YEAR	3. TIME OF DEA	ТН	
	4. SOCIAL SECURITY NUMBER		(In yrs. last i	birtnday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF 1		8. BIRTI	HPLACE (State or F	Foreign	
	220–14–6953	1 M 2 X F	72	YRS.	MONTHS DAYS	HOURS MIN.	July !		2 Mary	w zland		
æ	9a. FACILITY NAME (If not institution, give str					R LOCATION OF D	EATH		9c. COUNTY OF C	DEATH		
DIRECTOR	7700 Wilson Aven	ue			Par	kville						
REC	10a. STATE 10b. COUNTY			10c. CITY	TOWN OR LOCAT					10d. INSIDE CIT	Υ	
	Maryland 10e. STREET AND NUMBER					kville	10- CITIZEN (1 TYES 2	NO NO	
FUNERAL	7700 Wilson Aven				101	2123	34			S.A.		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S., FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES.			ARMED 13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Maxican 1 YES 2 NO Specify			an, Puarto Rican, atc.)			E — American Ind k, Whita, atc. iiiy: White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			EDENT'S U	ISUAL OCCUPATIO	N et of working	16b. KIND OF BUSINESS/INDUSTRY					
9	Elementary/Secondary (0-12) College (1-4 or 5 +)			(Give kind of work done during most of working life. Do NOT use retired.)				Oten Homo				
M M	17. FATHER'S NAME (First, Middle, Last)	ŀ	Iomen	naker		Own Home						
8	17. FATHER'S NAME (First, Middle, Last) Hunter Arnold Sr. Margaret Franklin											
BE	19a. INFORMANT'S NAME (Type/Print)	•	19b.	MAILING	ADORESS (Street a	nd Number or Rural			State, Zip Code)			
2	Iola Boblitz	(Sister)	49	935 (Columbia	Road Ap	ot. G	Colum	mbia, Ma	ryland	21044	
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Ramo	val trom State Ce	metery, cremi	etory or oth	er place)		DATE	20c. LOCAT	TION — City or To	own, Stata		
	20b. PLACE AND DATE OF DISPOSITION DATE 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, Stata											
	· Jusseecu	Jethe			Lerov	M & Russ	sell C	Witzk	e Funer	al Home	S	
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fallure. List only one cause on each line. Approximate interval Batween											
	IMMEDIATE CAUSE (Final			2	2					Onset an		
	disease or condition resulting in death)	ral	(arcin	ma				Gm	(0)		
_	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Coral Carcing Carcing											
CERTIFICATION	Sequantially list conditions, If any, leading to immediate b. Due to (Or As A Consequence OF):											
S	cause. Entar UNDERLYING CAUSE (Disease or injury	•										
	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEOU	ENCE OF)								
E	d											
DICAL	PART II. Other significant conditions	contributing to death	but not ras	ulting In	the underlying	causa given in	Part i. 24s	. WAS AN AU		. WERE AUTOPSY F		
8								YES 2	No	COMPLETION OF OF DEATH?	CAUSE	
ME	DID TOPACCO HEE CONTR	IDUITE TO CALICE A	35 DE 47			/				1 YES 2	NO	
AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE ((Check only one)	LUNCERTAII	иПТ					
SIC		HOSPITAL: 1 Inpetient 2 ER/Out			OTHER:	5- Raaldence	S ☐ Other /So	ecifu)				
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)		28b. TIME INJU	OF 28c, INJ	JRY AT			URY OCCURED			
BY	Natural 5 Pending 2 Accident Investigation				M 1 🗆 Y	ES 2 NO						
	3 Suicide S Could not be detarmined	28s. PLACE OF INJUR building, atc. (Spe	Y — At home scify)	e, tarm, st	reet, factory, offici		28t. LOCATIO City or To	N (Street and wn, State)	Number or Rural F	Route Number,		
COMPLETED		EIAN: To the best of my known: On the best of examination								a) and manner as	stated.	
E C	296, SIGNATURE AND TITLE OF CERTIFIER	2 10				29c. LICENSE NUI	MBER	2	9d. DATE SIGNED	(Month, Day, Year)		
10 8	14 Mai	0,100				2305	29		12/1	2/54		
	PAUL CEUMD	MO 65	69 A	27) (Typo, F	hurles	ST #	205) \$	Beim	ve m	2120	4	
	DEC13 1994	32. REGISTRAR'S SIGN	SATURE							-		

BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

for use as the burial-transit nours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 nours after death. Page 6 may be retained by the hospital TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COMPLETED BY

BE (

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3 Suicide

4 Homicide 29a. CERTIFIER

	ML									94	3	6688	
	FOR STATE REGISTRAR	STATE OF M	MARYLAND /				HEALTH AN	D MENT	AL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DA	TE OF DEATH	· ·	YEAR	3. TIME OF DEA	тн
	DEAMES		Ε.		BROOKS DEC						94	8:05	A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER 24 HR	40.4	E OF BIRTH oth, Day, Year)		6. BIRTH Count	IPLACE (State or Fo	oreign
	212-23-2537	1X M 2 □ F	8	YRS.	MONTHS	DAYS	HOURS MIN	NOV	.14, 19	986		vland	
	9a. FACILITY NAME (If not institution, give :	street and number)		96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT									
e l	johns hopkins	hospit	al	BALTIMORE CITY					N/A				
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT			10c. CITY, TOWN OR LOCATION									
E		/A			Balti							10d. INSIDE CITY	
											1 X YES 2	NO	
RA		101. ZIP CODE								WHAT COUNTRY?			
FUNERAL	4111 Brendan Ave					21213				J.S.A			
	1 Never Married 2 Married	YES 2 XI							or No-		E — American Indi k, White, atc.	en,	
B	3 Widowed 4 Divorced				3.7						Spec	"y: Black	
8	15. DECEDENT'S EDU	16e. DE	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUS					DUSTRY					
	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +)			Do NOT u	se retired.)								
린	3rd N/A CHILD-STUDENT									n/a			
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)												
BE (Deames E. Brooks, Sr. Bernadett								Hollar	nd			
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
F	Deames Brooks 4111 Brendan Ave./Baltimore, MD 21213												
	20a. METHOD OF DISPOSITION 1 Burial 2 XXCremation 3 Ram	oval from State	20b. PLACE					1	OATE 20C. LOCATION — City or Town, State 12-14 BALTIMORE, MARYLAND				
	4 Donetion 5 Other (Specify)		GREE	NMOU		_		12-1	4 BAL	TIMO	RE, M	ARYLAND	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	\cap				Funera		e Fast				
	del V.	Stollo	mel.				E. NORT			more	e, MI	21202	
	23. PART I. Enter the diseases, or	complications tha	t caused tha de	ath. Do	not antar	tha mo	oda of dying, a	uch as ca	rdiac or respi	ratory ar	reat,	Approxim	
	shock, or heart fallura. List only one cause on each line. IMMEDIATE CAUSE (Final											Interval B	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) A Head injuries DUE TO (OR AS A CONSEQUENCE OF):											j	
	rosanny m duarny	DUE TO	OR AS A CONSEC	DUENCE O	F):							1	
Z	Conventielly list and dates	b											
RTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F);								
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
E I	that initiated events resulting in death) LAST	OUE 10	(OR AS A CONSEC	DUENCE O	F):							İ	
CER		d											
	PART II. Other significant condition	s contributing to	daath but not r	esulting	In the unc	darlyln	g cause givan	In Part I.	24a. WAS AN	AUTOPSY	24b	. WERE AUTOPSY F	INDINGS
2									PERFOR			AVAILABLE PRIOR	
									1 X YES 2	□ 40		OF DEATH?	40
2	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH Y	S 🗆 N	10 L	UNCERT					1 X YES 2 □ I	NO
AN	25. WAS CASE REFERRED TO MEDICAL				TH (Check o		- OIACEKI	70.4					
Sic	EXAMINER?	HOSPITAL:			OTHER	:	ne 5 🗆 Residen	na -8 [] eu	har (Charita)				
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28a. OATE OF	INJURY	26b. TIM	E OF	28c. IN.	IURY AT	_	ESCRIBE HOW II	JURY OC	CURED		
D.	1 Netural 5 Dending	(Month, O	By, Year)	IN	IURY	WC	PRK?						

1X YES 2 □ NO 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Oay, Year) 1 Netural 12/09/94 2 Accident

26b. TIME OF INJURY 2100 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify)

28c. INJURY AT WORK? 1 YES 2 NO

SUBJECT STRUCK BY AUTOMOBILE 281. LOCATION (Street and Number or Burel Route Number City or Town, State) BALTIMORE M
2000 BLOCK BELAIR ROAD

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated. 2 💢 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

29b. SIGNATURE AND TITLE OF CERTIFIER	_
Wonald F. Wright MD	
TO MANUE AND ADDRESS OF PERSON WILLIAMS	_

O.C.M.E.

29d. DATE SIGNED (Month, Day, Year) DEC.11,1994

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD

31. DATE FILED (Morith, Day, Year)
DEC1 3 1994 32. REGISTRAR'S SIGNATURE Stwoler Radall

8 Could not be

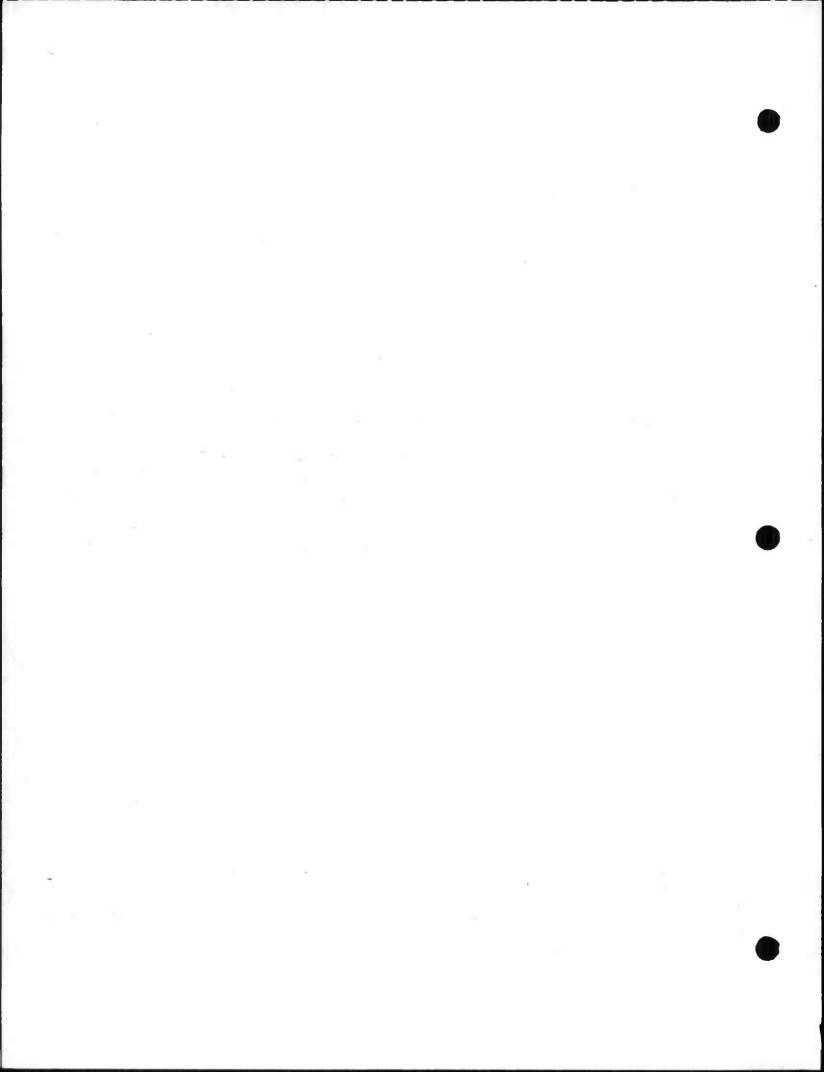
111 Penn Street, Baltimore, Maryland 21201

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Francis	J		LLOCK		December 8	1994	3:25 a M		
	4. SOCIAL SECURITY NUMBER 216-07-8383	1 😾 M 2 🗆 F	74 YRS. MON	THS DAYS	HF UNDER 24 HRS. HOURS MIN.					
R	9a. FACILITY NAME (If not institution, give str Franklin Squa		,	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
CTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Te Mospital			опе					
DIRECTOR	250	ltimore	10c. CITY, 10	WN OR LOCATIO	ssex	10d. INSIDE CITY LIMITS? 1 YES 23 NO				
FUNERAL	10e. STREET AND NUMBER	D 1		10f. 2	CIP CODE		CITIZEN OF WHAT COUNTRY?			
UNE	1024 Middles 11. MARITAL STATUS	S. ARMED	13. WAS DECE	212	Z Z I		ACE — American Indian,			
B⊀	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 XYES 2 IF YES, GIVE WAR OR DATES	. □NO	If yes, spec	Ify Cuban, Maxicar	n, Puerto Rican, etc.)	180	ack, Whita, alc. White		
TE	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	(Give kind of work of life. Do NOT use retir	lone during most	of working	16b. KIND OF BU	SINESS/INDUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Checke			Le	ver Br	others		
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden				
H	Joseph Bull 198. INFORMANT'S NAME (Type/Print)	ock	19b. MAILING ADD	RESS (Street and		eline Wi				
유	Linda Bullock					ad Balti				
	20e. METHOD OF DISPOSITION 15XBurlel 2 Cremelton 3 Removal from State 4 Donalton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) Oak Lawn Cemetery 12/12/94 Baltimore Md.									
	21. SIGNATURE OF FUNERAL SERVICE LICE		V Pawii		ADDRESS OF FAC		Dartim	ore ma.		
	R. Terry	Councill	/,			uneral H		Essex Md. 21221		
	23. PART I. Enter the diseases, or o	omplications that caused the	e denth De not e	nter the mode	of dying, such	ea cardlec or resp	iratory errest,	Approximata		
	IMMEDIATE CAUSE (Final	ist only one cause of each						interval Between Onset and Death		
i	disease or condition resulting in death) a. Pulmonary hemorrhage-massive 15 minutes Due TO (OR AS A CONSEQUENCE OR:									
N	Sequentially list conditions b. Lung cancer									
ATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE OF):							
JFIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF):							
CERTIFICATION	resulting in death) LAST									
AL	PART II. Other significant conditions			e underlying	cause given in I	Pert i. 24s. WAS AN		4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
PHYSICIAN: MEDIC	Bladder cancer,					1 YES 2	E	COMPLETION OF CAUSE OF DEATH?		
Σ.	myocardial infa DID TOBACCO USE CONTR		DEATH YES Σ	NO I	UNCERTAIN		i	1 TES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEATH (C	neck only one)	OTTCERTAIL					
YSI	1 TYES 2 X NO	1 Xinpetient 2 - ER/Outpatie		HER: Nursing Home	5 Realdence	6 Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	26c. INJUR WORK		26d. DESCRIBE HOW I	NJURY OCCURED			
D BY	2 Accident Investigation 3 Suicide a Could not be	28s. PLACE OF INJURY — / building, etc. (Specify)	At home, farm, street,			28t. LOCATION (Street	and Number or Run	I Route Number,		
ETED	4 Homicide detarmined	Committee (Grown)				City or Town, State)	_			
COMPLET		CIAN: To the best of my knowledge t: On the basis of examination and						e(a) and manner as stated.		
		BER	29d. DATE SIGN	time, data and place, and due to the cause(s) and manner as stated. IBER 29d. DATE SIGNED (Month, Day, Year)						
面 II	296. SIGNATURE AND TITLE OF CERTIFIER	D 1			1111.1.	2 /		EU (Month, Day, 1987)		
TO BE	Bonita U.	Portur)	(ITEM 27) (None Delay)		4440	737	12	0894		
	30. NAME AND ADDRESS OF PERSON WHO Bonita J. Port 31. Date Filed (Month, Day, Veer)		0 Frankli		<u> 4440</u> re Drive	Baltimor	e Maryl	0894		



1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS.

		Mary Catherine Brown	2. DATE OF DEATH MONTH 12 - 7 - 94 3. TIME OF DEATH						
10		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER t 1 M 2 K F 69 YRS.	t YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Dec. 31, 1924 Baltimore, Md.						
1, 2, 3 should			TOWN OR LOCATION OF DEATH Ston 1 Sto						
DAZO physician. burial-transit permit. Pages		Maryland Harford BelAir	LIMITOR						
		100. STREET AND NUMBER 427 Maitland Street	101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21014 U.S.A.						
		3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, yes, specify Cuban, Maxican, Puarto Rican, etc.) YES 2 \(\text{No} \) No Specify: White						
or attending for use as the		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCC (Give kind of work done du life. Do NOT use retired.)	CUPATION 16b, KIND OF BUSINESS/INDUSTRY						
nours after death. Page 6 may be retained by the hospital in by the funeral director, page 5 should be detached to or removal. medical examiner must be notified at once.		10th Delicatesen 17. FATNER'S NAME (First, Middle, Last)	Mgr. Retail Foods 18. MOTNER'S NAME (First, Middle, Melden Surname)						
		Andrew J. Kassa	Anna Holdorf						
		Mr. Irvin L. Brown 427 Maitla	19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 Maitland Street BelAir, Md. 21014						
			l Grds. 12/10/94 BelAir,Maryland						
		E.	F. Lassahn Funeral Home						
		23. PART i. Enter the diseases, or complications that caused the deeth. Do not anter to ahock, or heart failure. List only one cause on each ilne. IMMEDIATE CAUSE (Finel	.750 Belair Road Kingsville, Md. 21087 the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Day Onset and Day						
withi. npletely cremati vent, t		disease or condition resulting in death) a. Chrom C Skilling out to (or as a consequence of):	line ulmonaugh fram years						
execution and to bur	CATION	Sequentially list conditions, if any, leading to immediate b. Course (Ref.) DUE TO JOR AS A CONSEQUENCE OF:	matry tailing year						
ertificate be ing physicia rgiene prior other trau	Ē.	that initiated events our injury	Cist and you						
the death ce y the attending Mental Hy Injury, or	CERT	- Adjesejes	402 year						
that the ed by the and In	EDICAL	PART ii. Other algoritional conditions contributing to death but not resulting in the und	PERFORMEO? 1 YES 2 NO COMPLETION OF CAUSE OF DEATN?						
red oeen sh	AN: M	DID TOPACCO LICE CONTRIBUTE TO CALLCE OF BEATLY VEG ET AL							
ATTENDING PHYSICIAN: The law THE State Dept. State Dept. 23 is marked, or item 23 is	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 No No No No No No No	: ng Nome 5 Rasidence 8 Other (Specify)						
DING PHYSI After this c death with	ВУ РН	2 Accident investigation	28c. INJURY AT WORK? 1 YES 2 NO						
ATTENDING FTDR: After after death	ETED	4 Nomicide determined	ry, offica 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
NGA I	COMPL		ne, data and place, and due to the cause(s) and manner as attated. Inlon, death occured at the time, data and place, and due to the cause(s) and manner as stated.						
TO THE POS TO THE UN De filed IMPORTAN	O BE C	296. SIGNATURE AND TITLE/OF CERTIFIER	29c. LICENSE NUMBER D16389 29d. DATE SIGNED (Month, Day, Year) 12/7/94						
10	F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PERFECTO C, VAVALAO, WY.	D. 1716 HARFORD RD FALLS TOWN 10210						
Ju		31. DIEC 103 1994 Juli Breeding Contact							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ter death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 should	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.3
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	wai.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	al examiner must be notified at once.
O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR

CAUSE (Disease or injury

29h. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

2

that initiated aventa

91 3669 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) BRANCH 2. DATE OF DEATH 11-25-94 3. TIME OF DEATN BOY Babu Branch 11 2.5 1:10 Q M 4. SOCIAL SECURITY NUMBER 5 SEX 7. DATE OF BIRTH (Month, Day, Year)
11-24-94 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 D F DAYS HOURS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH University Hospital DIRECTOR Baltimore n a RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland na Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3635 Edmondson Avenue 21229 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, alc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced Black 60 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) BE Nakisha Branch 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Nakisha Branch 3635 Edmondson Avenue, Balto, MD21229 20a. METNOD OF DISPOSITION
1 □ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE removal matory or other place; 4 □ Donation 5 □ Other (Specify)in state 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.Baltimore St,Balto,MD21201 23. PART I. Entar the disessea, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. Llat only one causa on each lina. Interval Batwean Onset and Daath IMMEDIATE CAUSE (Final disesse or condition resulting in death) Immoru Ray ULMONARY DUE TO (OR AS A CONSEQUENCE OF): EXTREME PREMANUERY Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING

PART II. Other algorificant condition	a contributing to death but not	reaulting in the c	underlying cause givan is	Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATH (Chec	k only one)	N 🗆	<u> </u>	
1 TYES 2 NO	1 Nonpatient 2 - ER/Outpatient	3 DOA 4 N	:H: ursing Home 5 ☐ Residence	6 🗆 Oth	er (Specify)	
27. MANNER OF DEATN 1 Neturel 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28d. DE	SCRIBE NOW INJURY OCCU	RED	
3 Suicide 8 Could not be determined	28a. PLACE OF INJURY — At h building, atc. (Specify)	ome, farm, street, fa	CATION (Street and Number or Rural Route Number, y or Town, State)			

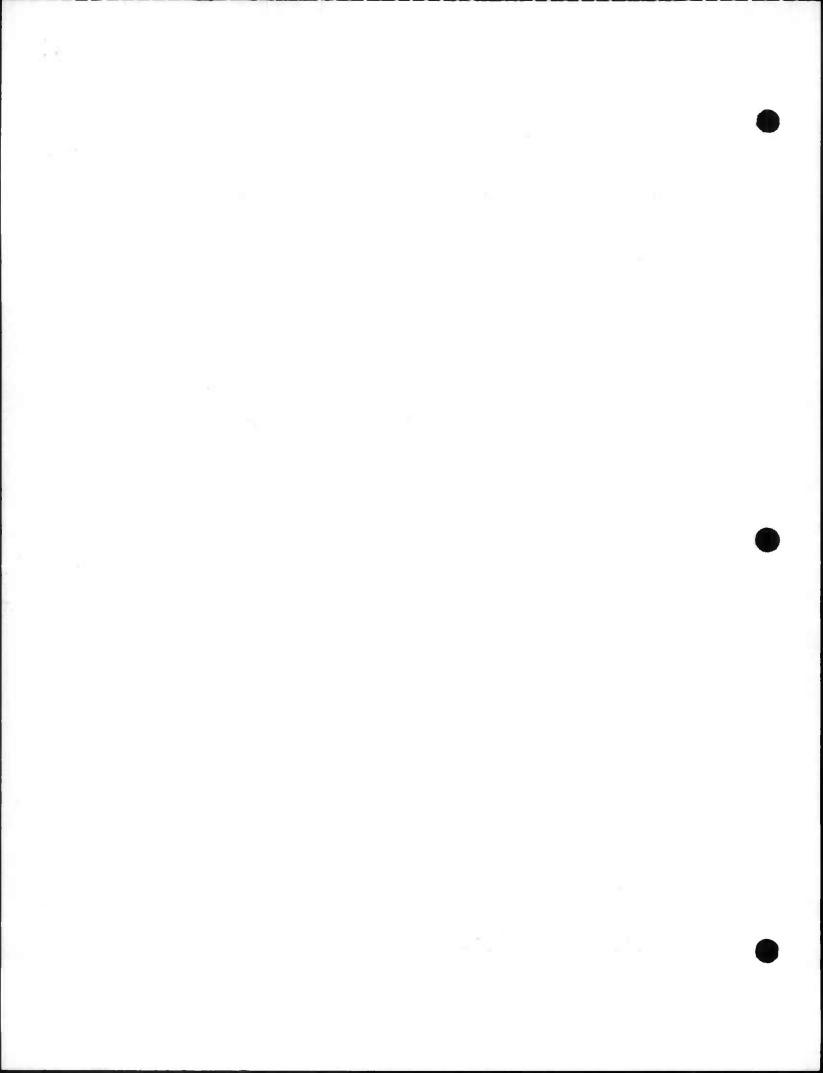
29c. LICENSE NUMBER

DUE TO (OR AS A CONSEQUENCE DF):

NEONATAL FELLOW

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Talia Davilson Roydall 29d. DATE SIGNED (Month), Day, Year)

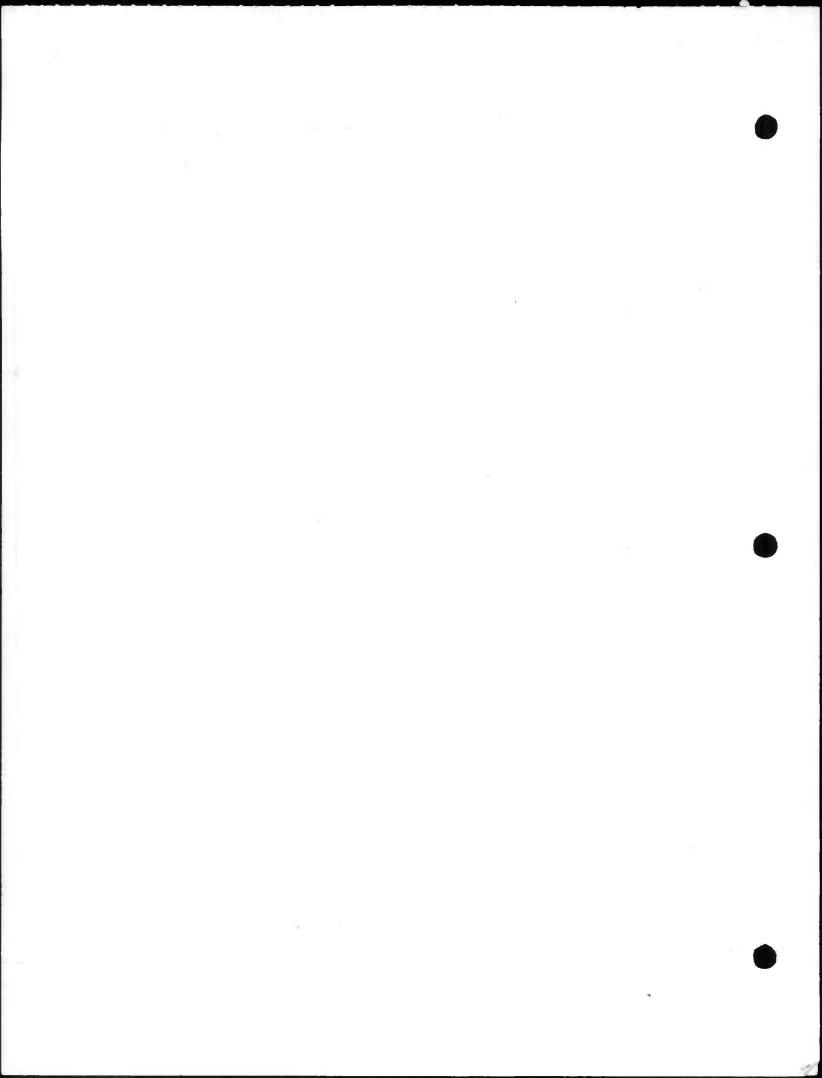


BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760. 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First, Middle, Leat) STEVE BODNAR 2. DATE OF DEATH DEC. 02 1994 6:39												
	SECURITY NUMBE	FR	5. SEX	6. AGE (In yrs	ingt hirthday	IF UNDER 1	VEAR	IF UNDER 24 HRS.	7 DATE OF	DISTIL			151 105 15
4. 500121	. SECONIT ! NOMBE		1 XM 2 F	7			DAYS	HOURS MIN.	7. DATE OF (Month, D	ay, Ybar)		8. BIRTH	HPLACE (State or Foreity)
9e FACII	TY NAME (If not ins	attution also et	7565		J 1113.	Oh CITY T	TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
	99. FACILITY NAME (If not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH 524 N. CHARLES STREET BALTIMORE CITY 9c. COUNTY OF DEATH								DEATH				
O n	NCE OF DEC		OT KEET			חאם	T TI	TOKE CI	1 1				
ILI 10e. STAT		10b. COUNTY			10c. CIT	Y, TOWN OR							10d. INSIDE CITY LIMITS?
Mar Mar	yland		n	a ————————————————————————————————————		Balt	imo	ore					1 YES 2 NO
	N. Cha	arles	Street	#60	1		10f.	ZIP CODE 2 1 2 0	1		10g. CITIZ	EN OF	WHAT COUNTRY?
	AL STATUS or Merried 2 owed 4 Divor		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Speci If yea, specify Cuben, Mexicen, Puerto Rican, et 1 YES 2 NO Specify:							
<u>ا</u> ا						EDENT'S USUAL OCCUPATION 18b				ND OF BUS	INESS/INDU	USTRY	
Щ Eleme	(Specify only htery/Secondary (0-		College (1-4 or 5+		(Give kind of a	work done dui se retired.)	ring mos	at of working					
Eleme T7. FATHE													
0 17. FATHE	R'S NAME (First, Mic	ddle, Last)				18. MOTHER'S NAME (First, Middle, Meiden Surname)							
H H													
9 19 . INFO	RMANT'S NAME (Ty)	pe/Print)			19b. MAILING	ADDRESS (Street er	nd Number or Rural i	Route Number,	City or Town	n, Stete, Zip	Code)	
				$\overline{}$,			
1 🗆 Burk	100 OF DISPOSITION 2 Cremation	n 3 🗆 Remo		cametary	CEANODATE (ON (Nat	na of	DATE	20c. LO	CATION C	Otty or To	own, State
4 L Don	tion 5 Other	SPECIFY) IT	state	remo.	val	22.01	505 404	D ADORESS OF FA	04 1774				
X	1. 201	11	ENSEE Ronal	d Wa	de,Di	r			SL				y Board
1	23. PART 1. Enter the diseases, or complications that caused the death. Do not snter the mode of dying, such as cardiac or respiratory arrast,										21201		
CAUSE that init	disease or condition resulting in dasth) a. Atterosclaratic Curdiovascular disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
resulting	in dasth) LAST	a d	l,										I
11													
	Other significan	nt conditions	contributing to	desth but no	ot resulting	in the unde	erlyina	csuse givan in	Part I. 24	a. WAS AN	ALITOPSY	24h	WERE AUTORSY EINE
	Other significan	nt conditions	contributing to	desth but ne	ot rssulting	in ths unde	erlying	csuse givsn in		a. WAS AN	MEO?	24b	. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAU
EDICAL EDICAL	Other significan	nt conditions	contributing to	desth but no	ot resulting	in ths unde	erlying	csuse givsn in			MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
WEDICAL MEDICAL									_ 1	PERFOR	MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
WEDICAL MEDICAL	TOBACCO US	SE CONTR	s contributing to	JSE OF D		S 🗆 N	0 🗆		_ 1	PERFOR	MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
WEDICAL MEDICAL	TOBACCO US	SE CONTR		JSE OF D	EATH YE	S NO	O 🔲	UNCERTAII	1	PERFOR	MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
WEDICAL MEDICAL	TOBACCO US	SE CONTR	RIBUTE TO CAU	JSE OF D 28. P ER/Outpatien	EATH YE	S NOTHER:	O D y ona) g Home 6c. INJU	UNCERTAIN 5 1/2 Residence	1	PERFOR YES 2	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
PART II. DID 25. WAS C EXAM 27. MANNI 11 N	FOBACCO US ASE REFERRED TO INER? INER? INER 2 INO INER OF DEATH Inturel 5 IP	SE CONTR	RIBUTE TO CAL	JSE OF D 28. P ER/Outpatien	EATH YE	S NOTHER: 4 Nursin E OF URY	O Dy ona) g Home Bc. INJU	UNCERTAIN 5 1/2 Residence	1 Other (S	PERFOR YES 2	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
PART II. DID 1 25. WAS CC EXAM 1	SE REFERRED TO INER? TES 2 NO OR OF DEATH attural 5 P cockdent ulcide 6 C	SE CONTR	HOSPITAL: Inpetient 2 28e. DATE OF (Month. Da	JSE OF D 28. P ER/Outpatient NJURY , Year)	EATH YE LACE OF DEAT 3 DOA 28b, TIM	S NG NG OTHER: 4 Nursin E OF 26	O D y ona) g Home 8c. INJU WOF	UNCERTAIN 5 \$\infty \text{Residence} 18Y AT 18Y 2 18Y 2 18Y 2 18Y 2 18Y 2 18Y 2 18Y 2	6 Other (S) 28d. DESCRI	PERFOR YES 2	MEO?	TURED	AVAILABLE PRIOR TO COMPLETION OF CAU DF DEATH?
PART II. DID 1 25. WAS CO EXAM 1	ASE REFERRED TO INER? (YES 2 NO RER OF DEATH stural 5 P incident in ulcide 6 C comicide 6 C	Dending restigation could not be etermined	HOSPITAL: Inpatient 2 26e. DATE OF (Month, Da	JSE OF D 28. P ER/Outpatient NJURY (, Year) INJURY — Att. (Specify)	EATH YELACE OF DEAL 3 DOA 26b. TIM INJ	S NG NG CHECK online OTHER: 4 Nursin E OF URY M street, fectory	y ona) g Home 8c. INJU WOF 1	UNCERTAIN 5 to Residence inty art ikk? ES 2 NO	6 Other (S) 28d. DESCRI	PERFOR YES 2 Decity) Decity) ON (Street e own, State)	MEO?	Or Rural F	AWALABLE PRIOR TO COMPLETION OF CAL DF DEATH? 1 YES 2 NO
PART II. DID 1 25. WAS CO EXAM 1	ASE REFERRED TO INER? (YES 2 NO ER OF DEATH INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INT	Dending mestigation Could not be etermined	HOSPITAL: t Inpatient 2 26e. DATE OF (Month, Da 26e. PLACE OF building, e	JSE OF D 28. P ER/Outpatient NJURY , 'Vear' INJURY — Al tc. (Specify) my knowledge	EATH YELACE OF DEAL 3 DOA 26b. TIM INJ t home, ferm, d	SS N(Check onl) OTHER: 4 Nursin E OF URY M street, fectory	g Home Sc. INJL WOF 1 Y, office	UNCERTAIN 5 to Residence 16 to Residence 16 t	6 Other (S) 26d. DESCRI 28f. LOCATE City or R	PERFOR YES 2 Decity) BE HOW IN ON (Street e own, State)	MEO? JURY OCCI and Number of	or Rural F	AVAILABLE PRIOR TO COMPLETION OF CAL DF DEATH? 1 YES 2 NO
PART II. DID 1 25. WAS CC EXAM 1	SERFERRED TO INER? FOR OF DEATH stural 5 Proceeding to the process of the proces	Pending mestigation Could not be etermined	HOSPITAL: t Inpatient 2 26e. DATE OF (Month, Da 26e. PLACE OF building, e	JSE OF D 28. P ER/Outpatient NJURY , 'Vear' INJURY — Al tc. (Specify) my knowledge	EATH YELACE OF DEAL 3 DOA 26b. TIM INJ t home, ferm, d	SS N(Check onl) OTHER: 4 Nursin E OF URY M street, fectory	g Home Sc. INJL WOF 1 Y, office	UNCERTAIN 5 to Residence IRY AT 187 ES 2 NO end plece, end due ath occured at the	6 Other (S) 26d. DESCRI 28f. LOCATIC City or %	PERFOR YES 2 Decity) BE HOW IN ON (Street e own, State)	MEO? AJURY OCCI and Number of the state of due to the	or Rural F	AWALABLE PRIOR TO COMPLETION OF CAL DF DEATH? 1 YES 2 NO
PART II. DID 1 25. WAS CC EXAM 1 27. MANNI 2 A 3 S 4 H 290. CERT (Checione)	ASE REFERRED TO INER? (YES 2 NO ER OF DEATH INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INTUINING INT	Pending mestigation Could not be etermined	HOSPITAL: t Inpatient 2 26e. DATE OF (Month, Da 26e. PLACE OF building, e	JSE OF D 28. P ER/Outpatient NJURY , 'Vear' INJURY — Al tc. (Specify) my knowledge	EATH YELACE OF DEAL 3 DOA 26b. TIM INJ t home, ferm, d	SS N(Check onl) OTHER: 4 Nursin E OF URY M street, fectory	g Home Sc. INJL WOF 1 Y, office	UNCERTAIN 5 to Residence 18 to Residen	6 Other (S) 28d. DESCRI 28f. LOCATIC City or R to the cause(PERFOR YES 2 Decity) BE HOW IN ON (Street e own, State)	MEO? AJURY OCCI and Number of the due to the 29d, DATE	or Rural F	AWAILABLE PRIOR TO COMPLETION OF CAU DE DEATH? 1 YES 2 NO Route Number, Route Number, (Month, Day, Year)
PART II. PART II. DID 25. WAS C EXAM 1	ASE REFERRED TO INER? TES 2 NO OF OF DEATH atural 5 P coldent ulcide 6 C comicide d d IFIER 1 CERTII 2 MEDIC ATURE AND TIPLE 4	Pending meetigation could not be etermined	HOSPITAL: 1 Inpetient 2 26e. DATE OF I (Month, De) 26e. PLACE OF building, e	JSE OF D 28. P ER/Outpatient NJURY , Year) INJURY — Atte. (Specify) my knowledge smification end	EATH YE LACE OF DEAT 1 3 DOA 28b. TIM INJ t home, ferm, d	IN (Check onl) OTHER: 4 Horsin E OF URY M street, fectory	g Home Sc. INJL WOF 1 Y, office	UNCERTAIN 5 to Residence IRY AT 187 ES 2 NO end plece, end due ath occured at the	6 Other (S) 28d. DESCRI 28f. LOCATIC City or R to the cause(PERFOR YES 2 Decity) BE HOW IN ON (Street e own, State)	MEO? AJURY OCCI and Number of the due to the 29d, DATE	or Rural F	AWALABLE PRIOR TO COMPLETION OF CAU DF DEATH? 1 YES 2 NO Route Number,
PART II. DID 25. WAS C EXAM 27. MANNI 1 N 2 A 3 S 4 H 290. CERT (Chec. One) 29b. SIGN. 30. NAME OM 30. NAME	ASE REFERRED TO INER? TES 2 NO OF OF DEATH atural 5 P coldent ulcide 6 C comicide d d IFIER 1 CERTII 2 MEDIC ATURE AND TIPLE 4	Pending restigation could not be eletermined FYING PHYSIC CAL EXAMINER PERSON WHO	HOSPITAL: t Inpatient 2 26e. DATE OF (Month, Da 26e. PLACE OF building, e	JSE OF D 28. P ER/Outpatient NJURY , 'bear' INJURY — At the (Specify) my knowledge impression and the control of the contr	EATH YE LACE OF DEAT 3 DOA 28b. TIM INJ t home, ferm, of death occurre /or investigatio	OTHER: 4 Norsin OTHER: 4 Norsin A	g Homes g Homes g Homes yor yor to yor t	UNCERTAIN 5 \$\infty \text{Residence}\$ IRY AT IK? ES 2 _ NO end piece, end due ath occured at the 29c. LICENSE NUM O . C . M	6 Other (S) 28d. DESCRI 28f. LOCATIC City or R to the cause(time, date enc	PERFOR YES 2 Decity) DN (Street e own, State) e) end man	MEO? JURY OCCI nor ee state d due to the 29d. DATE	or Rural F	AWALABLE PRIOR TO COMPLETION OF CAL DF DEATH? 1 YES 2 NO Route Number, 1 (Month, Day, Year)

DEC 13 1994

		FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF F		MENTAL HYGIE				
		1. DECEDENT'S NAME (First, Middle, Last) PETER			BUT		2. DATE OF DEATH		3. TIME OF OEATH 11:15 A		
10		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	7 1 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH 1 - 12 - 1992	2.3	BIRTHPLACE (State or Foreign Country)		
2, 3 should	стон	99. FACILITY NAME (If not institution, give st	CANADA MARKATA			OR LOCATION OF DE	9c. COUNTY OF DEATH				
Pages 1,	뿐	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY Maryland	Y		ry, town on Loca Ltimore				10d. INSIDE CITY LIMITS?		
isit permit.	HAL	100. STREET AND NUMBER 6511 O'Donne			10	of. ZIP CODE		1 VES 2 NO			
-AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 Tyes IF YES, GIVE WAR OR D	2 NO	tf yes, sp	CENDENT OF HISPAN pecify Cuben, Mexice S 2 NO Specify	ee or No— 14	RACE — American Indian, Black, White, etc. Specify: White			
	APLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	16a. DECEDENT'S (Give kind of the life. Do NOT us	USUAL OCCUPATION work done during modes retired.)	ON ost of working	16b, KIND OF B	D. KIND OF BUSINESS/INDUSTRY				
# EE	SE COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, Middle, Maide	n Surneme)			
ay be retained page 5 should be notified	TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	and Number or Rural I	Route Number, City or To	wn, State, Zip Co	ide)		
e 6 may ector, pa		20e. METHOD OF DISPOSITION 1	n state ref		other place)			OCATION — City			
death. e funer. li.		21. SIGNATURE OF FUNERAL SERVICE LICENSER On ald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate									
in z= nours aft by filled in by ation, or remo		snock, or heart failure. I	List only one ceuse on a	each line.					Interval Between Onset and Death		
B 5 - 6	NO NO	disease or condition resulting in death) a. Atterosuleruh 2 (ardiovius cultur discuse) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
ar cian	RTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
ath c	CERTII	reaulting in deeth) LAST									
res that the signed by the lealth and Muse ws any injury	MEDICAL	PART II. Other eignificent condition	e contributing to deeth b	out not reculting	in the underlying	g ceuee given in	Part I. 24s. WAS A PERFO	PAMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
law as b		DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	OF DEATH YE			<u> </u>		1 169 2 110		
- F 2 8 5	PHYSICIAN:	EXAMINER? XXYES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Out	patient 3 🗆 ODA	OTHER: 4 - Nursing Hom	ne 5 Residence					
ATTENDING PHYSICIAN: ECTOR: After this certifica s after death with the St 1 28 is marked, or it	ву рн	1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		M 1 .	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW				
OR ATTENDI DIRECTOR: A hours after di	COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	f — At home, farm, sicify)	street, fectory, offic		28f. LOCATION (Street City or Town, State		Rural Route Number,		
DIRECTOR A	MPL		CIAN: To the best of my know						euse(e) end menner ee stated.		
DSPITA JNERAL Ithin 72 INT: 16	유미	ΛΛ	296. SIGNATURE AND TITLE OF CERTIFIED 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, M								
TO THE HOSPITA TO THE FUNERAL Be filed within 72 IMPORTANT: II	BE	AA	Glas	/							
TO THE HOSPITAL OF TO THE FUNERAL DE FUNERAL	ш	29b. SIGNATURE AND JITLE OF CERTIFICE 30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE			O.C.M	I.E.	DEC	.02,1994 and 21201		



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

Item#1 Per F.H	. Film# G-71	8 12/13	3/94 R.	М.					
	STATE OF MARYLAND /	DEPARTMEN	T OF HEALTH	AND ME					
1. DECEDENT'S NAME (First, Middle, Last) V			E OF DEA		REG. NO.				
VICTOR L	CATLI	CARLILI	s, JR.	2	DATE OF DEATH	j 95	3. TIME OF DEATH		
	6. SEX 6. AGE (In yrs. las			7	DATE OF BIRTH		BIRTHPLACE (State or Foreign		
	M 2 □ F 63	YRS.	MONTHS DAYS HOURS MIN. (Month, Day, Year) Country) 12-18-1930 MARYLA						
9a. FACILITY NAME (If not institution, give street		96. CIT	Y, TOWN OR LOCAT		Н	9c. COUNTY	OF DEATH		
ST. AGNES HOSPI	T'AL		BALTI	MORE			NONE		
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION				Tank Mining Olty		
DELAWARE SUSS	SEX		FRANKFORD 1004. INSIDE CITY 1014. INSIDE CITY 1015. INSIDE CITY 10						
100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COU									
R.D. 1 BOX 175 B 19945 U.S.A									
11. MARITAL STATUS 12 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 VES 2 1		If yes, specify Cube		ORIGIN? (Specify Yes	or No- 14.	RACE — American Indian, Black, White, atc.		
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES 1951-1955		1 TES 2 NO	Specify:	dello Micell, etc.)		Specify: WHITE		
15. DECEDENT'S EDUCAT		CEDENT'S USUAL O	OCCUPATION		16b. KIND OF BUS	SINESS/INDUST	TRY		
	College (1-4 or 5 +)	Do NOT use retired.							
12	NONE EL	ECTRONI	C TECHI	NICIA	N F.A.	Α.			
17. FATHER'S NAME (First, Middle, Last) VICTOR L. CARLILE, SR. 18. MOTHER'S NAME (First, Middle, Maiden Surmame) EVELYN C. DAY									
19a. INFORMANT'S NAME (Type/Print)	190	b. MAILING ADDRES	S (Street and Numbe	er or Rural Rou	te Number, City or Town	n State Zin Coc	w 19945		
MRS. JOAN T. CA					FRANKFO	RD, DI	ELAWARE		
20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremellon 3 Remova 4 Donation 5 Other (Specify)	20b. PLACE / cemetery, cre	AND DATE OF DISPO	SITION (Name of MEMORIA	r. PK	2714/34 10	CATION — CITY	or Town, State		
21. SIGNATURE OF EUNERAL SERVICE LICEN		22	NAME AND ADDRE	SS OF FACIL	TY 0737 07 71	TTO VII	HELT MD.		
+ H. Jense	The lai				SINGLE' NUE, S. MARYLA		UNERAL HOME		
23. PART I. Enter the diseases, or con-	nplications that caused the de	ath. Do not anta	r the moda of dy	ing, auch a	a cardiac or reapi	ratory arreat,	Approximate		
ahock, or heart failure. Lia IMMEDIATE CAUSE (Final	it only one cause on each line						Interval Between Onset and Death		
disease or condition	50	,					100000000000000000000000000000000000000		
resulting in death)	DUE TO (OR AS A CONSEC	M/ /					Barets		
_	- CON AS A CONSE	delice or j.		1.			6 monds		
Sequantially list conditions, b	DUE TO (OP AS A CONSEC	d ispli	11716	J S N.	esome		6Months		
If any, leading to immediate cause. Enter UNDERLYING	DOL TO (OK AS A CONSEC	DUENCE ON							
CAUSE (Disease or Injury C	DUE TO (OR AS A CONSEC	DUENCE OF							
that initiated eventa resulting in death) LAST	22 12 (311 113 11 2011 22 2	JOENOE OF J.							
d									
PART II. Other aignificant conditions of	ontributing to death but not r	aaulting in the u	nderlying cause	given in Pa			246. WERE AUTOPSY FINDINGS		
					PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
					_ 1 \ YES 2	LI MO	OF DEATH?		
DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF DEA	TH YES 🗆	NO 🛮 UNO	ERTAIN			1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		E OF DEATH (Check	only one)						
	IOSPITAL: Inpatient 2 ER/Outpatient 3	DOA 4 Nu	R: rsing Home 5 A	asidence 8	Other (Specify)				
27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT		Bd. DESCRIBE HOW II	NJURY OCCURE	ED		
1 Netural 5 Pending	(Month, Day, Year)	INJURY M	WORK?	NO					
2 Sutelde	28a. PLACE OF INJURY — AI ho	me, farm, street, lac	tory, office	28	BI. LOCATION (Street a	nd Number or R	Jural Route Number		
4 Homicide 8 Could not be determined	building, atc. (Specify)				City or Town, State)	ind from the first	ere route runnes,		
29a. CERTIFIER Check only	N: To the bast of my knowledge, de	sth occurred at the	time, data and place	, and due to	the cause(s) and man	ner as stated.			
	On the basis of axamination and/or i						use(a) and manner as stated.		
296. SIGNATURE AND TITLE OF CERTIFIER			29c. LIC	ENSE NUMBE	R	29d. DATE SIG	GNED (Month, Day, Year)		
1 Journ			11	eru	en	12	110/84		

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

EMEGISTRANS SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALLIMORE, MARILAND ZIZIS-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pa, or removal.	medical examiner must be notified at once.
City of All All All All All All All All All Al	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAND /				IEALTH DEAT		MENT	AL HYGIEN			
. 1	t. OECEDENT'S NAME (First						-			2. DAT	TE OF DEATH	NA .	YEAR	3. TIME OF DEATH
1 8			Von O'Ne	il COCK	RELL						ember 6			2:00 am
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. les		IF UNDER	DAYS	IF UNDER	24 HRS.		TE OF BIRTH	_	8. BIRTI	HPLACE (State or Foreign
- 4	n/a		1 M 2 - F		YRS.	wonths	T	nouns	mere,	DE C	.5,1994			yland
	9a. FACILITY NAME (if not institution, give street and number)					9b. CITY	, TOWN	OR LOCATION	ON OF DE	EATH		9c. COU	NTY OF	DEATH
5	6118 St. Re		ad Hosp	lin Squa	are		n/a					Balt	imor	e County
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	Y Baltim		10c. CIT	ry, TOWN (OR LOCAL	ION						10d, INSIDE CITY
E	MD		partim	ore		, , , , , , , ,	n/a							LIMITS?
	10e. STREET AND NUMBER						_	ZIP COD	F			10a CIT	IZEN OF	t YES 2 NO
FUNERAL	6118 St. R	ogia P	500					10000				1,141		
Š	11. MARITAL STATUS	egis K	12. WAS DECEDEN	IT EVER IN U.S. AF	RMED	13.		21206	_	IIC ORIG	GIN? (Specify Yea		S.A	e E — American Indian,
	1 X Never Married 2		FORCES? 1	NO		If yes, sp	ecify Cuba 2 👿 NO	n, Maxica Specify	can, Puarto Rican, etc.)			Blac	k, White, atc.	
B	3 Widowed 4 Divo	rced						X	оросиј				Spec	Black
	15. DEC (Specify onl	EDENT'S EDUC y highest grade	CATION completed)	18a. DE	CEDENT'S	USUAL O	CCUPATIO	ON st of workin	107	1	66. KIND OF BUS	INESS/IN	DUSTRY	
91	Elementary/Secondary (I		College (1-4 or 5	fife	Do NOT u	se retired.)			.9					
MP	n/a		-		BA	ВҮ					n/	a		
COMPLETED	17. FATHER'S NAME (First, M										t, Middle, Maiden	Surname)		
B	Willie Coc							Lat	onia	a Co	oleman			
2	19a. INFORMANT'S NAME (mber, City or Tow			
	Rosa Coleman			6	118	St. I	Regi	s Roa	ad/Ba	alt:	imore,	Mary.	land	21206
	20a. METHOD OF DISPOSIT t)(XBurial 2 ☐ Cremetic	n 3 🗆 Reme	oval from State	20b. PLACE a cemetary, cre				ma of		D#	ATE 20c. LO	CATION —	City or To	own, State
	4 Donation 5 Other		TEMPER	KING		FMOR			RK_1		2 RA	NDAL	LST0	WN. MD
	March Funeral Home East													
	nel.	20	long	Χ.		1:	101	E. No	orth	Ave	enue/Ba	ltimo	ore,	MD 21202
	23. PART / Enter the d ehock, or h IMMEDIATE CAUSE (Fi disease or condition resulting in death)	eart failure. I	a. Severe	se on each line								ratory an	rest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Respiratory Distress Syndrome 14 hours b. Respiratory Distress Syndrome 15 hours 16 hours 17 hours 18 hours 19 hours 19 hours 19 hours 19 hours 19 hours 19 hours 10 (or as a consequence of):													
PHYSICIAN: MEDICAL	PART II. Other algnifice	nt condition	e contributing to	death but not r	reaulting	in the ur	derlyin	ceuae ç	jiven in	Part I.	24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE			
											1 TYES 2	AMO		OF DEATH?
=	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE OF DEA	TH Y	ES 🗆 I	NO EX	UNC	ERTAIN	vП				
X I	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL		26. PLAC	E OF DEA	TH (Check	only one)							
Sign	1 YES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nun		e 5 🗆 Re	aldence	6 🗆 Oti	her (Specify)			
£	27. MANNER OF DEATH		26a. DATE OF (Month, D		28b. TIN	IE OF	28c. INJ	URY AT		26d. D	ESCRIBE HOW II	NJURY OC	CURED	
BY		Pending Investigation	(1001111, 2	uy, roary		M		ES 2	NO					
	2 Sulate	Could not be	26a. PLACE O	F INJURY — At ho	me, ferm,	street, fact	ory, offic	1			CATION (Street a	nd Number	or Rural I	Route Number,
	4 Homicide	determined		oral (opposity)						Cri	ty or Town, State)			
COMPLETED	1		CIAN: To the best of											a) end manner as stated.
8				termination and/or	investigacio	on, in my o	pinion, a				ita and place, an			/.
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER							NSE NUM			29d. DAT	E SIGNED	(Month, Day, Year)
2	30 NAME AND ADDRESS OF	arau	M.			0.1		D	225	11		/	1/6/	94 25AM
	30 NAME AND ADDRESS OF	alli,		00 Fran			re I	rive	, F	Balt	imore.	MD	2123	37
	DEC 131	Year)	REGISTRA	R'S SIGNATURE										
	DEC 19	334	A more with	MANAGE INCOME	DEAN.									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE PATAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within the foath. Page 6 may be retained by the hospital or attending physician.

THE PATAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the men 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH			
	MARGARET	AUDRE		CLARK		DEC. 8	1994	7:00 p M			
	217/14/2066	4/2066 1 M 2 F 84 YRS. MONTHS DAYS HOURS MIN. (Morth) Day, Year) 7/3/1910									
ECTOR	NORTH ARINDEL HOSP			GLEN BL		9c. COUNTY OF DEATH A. A. COUNTY					
DIREC	MD AA	CO.		TOWN OR LOCAT	ION		10d. INSIDE CITY LIMITS? 1 ☐ YES ஆ∏ NO				
FUNERAL	10e. STREET AND NUMBER 10f. ZIP CODE						10g. CITIZEN OF	WHAT COUNTRY?			
NE I	1032 REECE ROA	2. WAS DECEDENT EVER IN			21144		USA				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR DA	2√XNO	If yes, sp		NIC ORIGIN? (Specify Yes in, Puerto Ricen, etc.) y:	Blo	CE — American Indian, ack, White, etc. acity: White			
TED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION mpleted)	18e. DECEDENT'S US (Give kind of wor	k done durina ma	ON st of working	16b. KIND OF BUS	SINESS/INDUSTRY				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) NA	SALES CI			DEPT	. STORE				
SON	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)				
BE	CHARLES CLARK				M		JEFFERY				
5	190. INFORMANT'S NAME (Type/Print) NORMAN W. CLARK,	IR	1			RN, MD 211					
	20a. METHOD OF DISPOSITION XI文 Burial 2 □ Cremation 3 □ Remove	20b.	PLACE AND DATE OF	DISPOSITION (Na	me of		CATION — City or	Town, State			
	4 Donation 5 Other (Specify)	7	FRIENDSHI				ANOVER,	MD			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Syx			ID ADDRESS OF FA	cility UNERAL HOMI	7				
_	22 PART I Street the discourse proper	us		GLEN	BURNTE	. MD 21061					
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Constant)										
	reaulting in death) OUE TO (OR AS A CONSEQUENCE OF):										
Z	DUE TO (OH AS A CONSEQUENCE OF):										
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING										
IFIC	that initiated eventa	DUE TO (DR AS A	CONSEQUENCE DF):		1010						
ERI	resulting in death) LAST										
AL (PART II. Other significant conditions of	contributing to deeth bu	It not resulting in	the underlying	causa given in	Part I. 24a. WAS AN PERFOR		6b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
PHYSICIAN: MEDIC	Denontie					1 _ YES 2		COMPLETION OF CAUSE OF DEATH?			
	DID TOBACCO USE CONTRIE	SUITE TO CAUSE OF	E DEATH VES	ПИОГ	UNCERTAI			1 TES 2 NO			
SIAN	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH	(Check only one)	UNCERIAII	<u> </u>					
YSIC	1 YES 2 NO 1	OSPITAC: https://example.com/spices/files/		THER:	5 🗆 Realdenca	8 Other (Specify)					
	27, MANNER OF DEATH 5 Pending	(Month, Day, Year)	28b, TIME (Y WO	URY AT RK? 'ES 2 NO	28d. DEŞCRIBE HOW II	NJURY OCCURED				
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	At home, farm, stre			281. LOCATION (Street a City or Town, State)	and Number or Rure	l Route Number,			
1976	29a. CERTIFIER (Check only	N: To the best of my knowle	edge, death occurred :	et the time, date	and place, and due	to the cause(e) and men	ner se stated				
COMPLETED	one) 2 MEDICAL EXAMINER:	On the basis of exemination	end/or investigation,	In my opinion, d	eath occured at the	time, date end place, an	d due to the cause	e(e) and menner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	me	Foe	0 1	29c. LICENSE NUI	_	29d. DATE SIGNE	(Month, Day, Year)			
5	30. NAME AND ADDRESS OF PERSON WHO C			-							
	ROBERT B. KROOPNICK			ROAD,	#203/GLE	N BURNIE, I	MARYLAND	21061			
	"DEC1 3 1994" Juli	PR. REGISTRAND SIGNA DRUGGER CANDA	<i>y</i>								

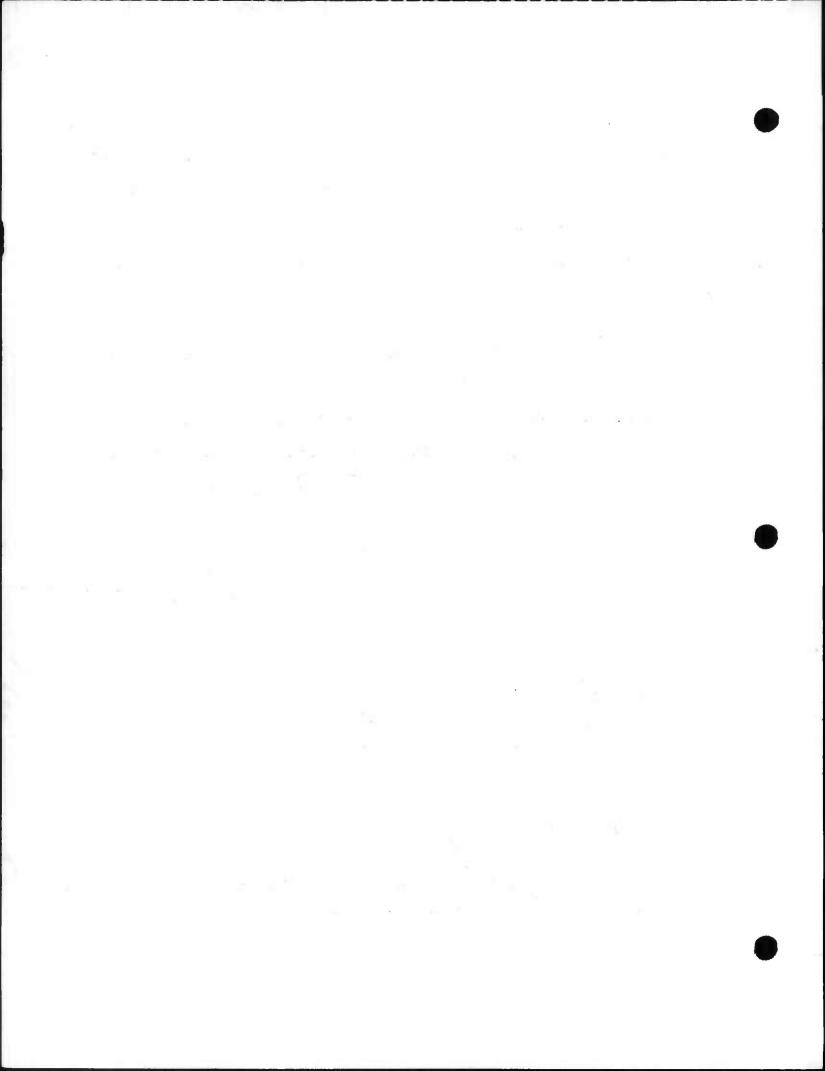
hours after death. Page 6 may be retained by the hospital or attending physician. of the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 CIAN: The law requires that the death certificate be executed within

at once.

	TO THE HOSPITAL OR ATTWORNS PROPERLY The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained	TO THE FUNERAL DIRECTOR memic perificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Debt. of Health and Mental Hydiene prior to burial, cremanion, or removal	IMPORTANT: if item 28 is marked; or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
1	пау ре	r, page	st be !
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	No P.	TO THE FUNERAL DIRECTOR PROFILES and finds the State Debt. of Health and Mental Hiviere prior to burial, cremation, or removal	татке
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	THE O	o THI	MPO
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

- 1	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR														
- 3	GEOF	M						12		YEAR 94	94 1:50 p M				
				6. AGE (In yr			F UNDER 1 YEAR IF UNDER 24 HRS.		7. DATE OF BIRTN			8. BIRTNPLACE (State or Foreign Country)			
	210-13-4850	1 🔀 M 2 🗌 F	86	YRS.	MONTHS	ONTHS DAYS HOURS M		MIN.	10-2	1. Year) 4-08		vland			
	9a. FACILITY NAME (If not institution, give street and number)					9b. CIT	9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEAT						4		
8	Edenwald					Towson Baltimore							re		
5	RESIDENCE OF DECEDENT														
2	Maryland Baltimore						OR LOCA	TION						10d. INSIDE CITY LIMITS?	
21	Maryland 100. STREET AND NUMBER	Tov	son	1 40	4 710 0001						1 YES 2 NO				
FUNERAL DIRECTOR	800 Southerly Rd.					101. ZIP CODE 21286								N OF WHAT COUNTRY?	
빌	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.								エとめり DENT OF HISPANIC ORIGIN? (Specify Yaa o				U.S.A.		
드	1 Never Married 2 Merried FORCES? 1 N. FORCES. 1 N. FOR				⊠ NO	"	If yes, specify Cuben, Maxicar 1 YES 2 X NO Specify				n, etc.)	or No-	14. RACE — American Indian, Black, White, atc.		
B	3 Wildowed 4 Divo	orced	W 123, GIVE V	MR OR DATES	•		T TES 2 LA NO Specify.			•			Specify: White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)					ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working					ID OF BUS	INESS/INE	DUSTRY		
91	Elementary/Secondary (C		College (1-4 or 5	life Do MOT une			e retired.)								
M M			4 yrs	Engine			eer				Electrical E			Engineer	
8		17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S					le, Maiden	Surname)			
BE	Thomas		Cun	ningha	em			Le	ah		And	ndrews			
2	19a. INFORMANT'S NAME (1									Route Number, (,		
	Charlotte C		ingham						. To	wson,					
	1 🗆 Burial 2 🖾 Crematic	20a. METNOD OF DISPOSITION 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State					SPOSITION (Name of blece)			DATE 20c. LOCATION - Cit					
4 Donation 5 Other (Specify) Hilltop Service Corp.										12-13 Towson, Md.					
	1	21. SIGNATURE OF FUNCTIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc.										nc.			
	n	- 11	10			1	.050	York	Rd.	Towso	n, M	d. 2	1204		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Batween														
	IMMEDIATE CAUSE (Final									Onset and Death					
	resulting in death) a. Yy monary EmBOLISM														
	disease or condition as Pulmonary Embolism Due to (or as a consequence of): Sequentially list conditions, Out To (or as a consequence of): Out To (or as a consequence of):														
S S	Sequentially list conditions, The TAS TOTIC Large work OF THE RETURN														
¥.	If any, leading to immediate csuse. Enter UNDERLYING														
CAUSE (Disease or injury															
드	that initiated events DUE TO (OR AS A CONSEQUENCE OF):														
RTIFI			DUE TO	(OH AS A CO	NSEOUENCE O	F):									
	resulting in death) LAS	T .	d												
CAL CERTIFICATION	resulting in death) LAS PART ii. Other significa	nnt condition	a contributing to	death but r	not rasuiting	In the u				Part I. 24	. WAS AN A		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
	PART II. Other significa	ant condition	a contributing to	death but r	not resulting	In the u				İ		MED?	24b		
MEDICAL CERTIF	PART II. Other signification of the CONGES	ent condition ERAT	a contributing to	death but r	ELLA	In the u	OT/	4×11	-	1[PERFOR	MED?	24b	AVAILABLE PRIOR TO COMPLETION DF CAUSE	
: MEDICAL	PART II. Other signification of the Condition of the Cond	ant condition ERAT TIVE ISE CONTE	a contributing to	death but r	ELLA ILUI DEATH Y	In the u	NO E	4×11		1[PERFOR	MED?	24b	AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
: MEDICAL	PART II. Other signification of the Communication o	ant condition ERAT TIVE ISE CONTE	a contributing to INE HEARI RIBUTE TO CA	death but r	ELLA ILUI DEATH YI PLACE OF DEA	In the u	NO E	1 UNC	ERTAIN	1	PERFOR	MED?	24b	AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
: MEDICAL	PART II. Other significa PART II. Other significa CONGES DID TOBACCO U 25. WAS CASE REFERRED TO	ant condition ERAT TIVE ISE CONTE	a contributing to	death but r	ELLA ILUI DEATH YI PLACE OF DEA	In the U	NO Conty one) R: raing Hom	0 × / / UNC	ERTAIN	1 [8 Other (Sp	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
PHYSICIAN: MEDICAL	PART II. Other significa PART II. Other significa CONGES DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Metural 5	Int condition ERAT TIVE SE CONTE	a contributing to	death but r	DEATH YI PLACE OF DEA	In the U	NO Conly one) R: raing Hom 28c. INJ WO	UNC	ERTAIN	1	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
BY PHYSICIAN: MEDICAL	PART II. Other signification of CE S DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANIYER OF DEATH 1 Metural 5 2 Accident	Int condition ECAT TIVE SE CONTR O MEDICAL Pending Investigation	a contributing to IVE RIBUTE TO CA HOSPITAL: 1 Inputient 2 28a. DATE OF (Month, D) 28a. PLACE O	death but r EVE C USE OF E 28. I ER/Outpetler INJURY ey, 'ber')	DEATH YI PLACE OF DEA	In the u	NO Confly one) R: raing Hom 28c. INJ WO 1 1	UNC UNC O 5 G Re URY AT ORK? YES 2	ERTAIN	8 Other (Sc 28d, DESCRII	PERFOR	MED?	CURED	AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDICAL	PART II. Other significa PART II. Other significa CONGES DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Mediural 5 2 Accident 3 Suicide 8	Int condition ERAT TIVE SE CONTE	a contributing to IVE RIBUTE TO CA HOSPITAL: 1 Inputient 2 28a. DATE OF (Month, D) 28a. PLACE O	USE OF E	DEATH YI PLACE OF DEA 28b. TIN	In the u	NO Confly one) R: raing Hom 28c. INJ WO 1 1	UNC UNC O 5 G Re URY AT ORK? YES 2	ERTAIN	8 Other (Sc 28d, DESCRII	PERFOR	MED?	CURED	AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDICAL	PART II. Other signification of DE C EN C EN C EN C EN C EN C EN C EN C	Int condition ECAT TIVE SE CONTE O MEDICAL Pending investigation Could not be determined	A contributing to A CAR	death but in USE OF [28. I ER/Outpatie INJURY ey, Year) F INJURY — etc. (Specify)	DEATH YI PLACE OF DEA 1 28b. TIM At home, term,	In the u	NO Conly one) FI: raing Hom 28c. INJ WO 1 1 1	UNC UNC IN 5 Re IURY AT INK? YES 2	ERTAIN sidence	8 Other (Sp. 28d. DESCRIII	PERFOR	MED? NO NO NO NO NO NUMBER	CURED r or Rural F	AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDICAL	PART II. Other significa PART II. Other significa CONGES DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANYER OF DEATH 1 Metural 5 2 Accident 3 Suicide 6 4 Nomicide	Int condition PATINE SE CONTE O MEDICAL Pending investigation Could not be determined	ACONTRIBUTE TO CA HOSPITAL: Dispriser 2 28a. DATE OF (Month, D) 28a. PLACE O building.	death but r EVE D USE OF E 28. (INJURY ay, vbar) FINJURY — etc. (Specify)	DEATH YI PLACE OF DEA At home, term,	In the u	NO [conly one) R: raing Hom WO 1 _ vitory, office	UNC UNC UNC UNC UNC UNC VES 2 and placa,	ERTAIN sidenca NO and due	8 Other (Sp. 28d. DESCRIII City or 7c	PERFOR YES 2 weethy) BE NOW IN (Street awn, State)	MED? NO IJURY Oci	CURED r or Rural F	AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO	
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significa PART II. Other significa CONGES DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANYER OF DEATH 1 Metural 5 2 Accident 3 Suicide 6 4 Nomicide	Int condition ECAT TIVE SE CONTR O MEDICAL Pending Investigation Could not be determined	CONTRIBUTE TO CA HOSPITAL: Description 2 28e. DATE OF building.	death but r EVE D USE OF E 28. (INJURY ay, vbar) FINJURY — etc. (Specify)	DEATH YI PLACE OF DEA At home, term,	In the u	NO [conly one) R: raing Hom WO 1 _ vitory, office	UNC UNC Be 5 Re UURY AT URY AT SPEC 2 Be and place, death occur	ERTAIN sidence NO and due	8 Other (Sc. 28d. DESCRII 28f. LOCATIOn City or R. 28f. Location to the cause(stime, date and	PERFOR YES 2 weethy) BE NOW IN (Street awn, State)	MED? NO NO NO NUMBER Number ner så stat	CURED r or Rural F	AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO Route Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other signification of the control of the	Int condition ECAT TIVE SE CONTR O MEDICAL Pending Investigation Could not be determined	CONTRIBUTE TO CA HOSPITAL: Description 2 28e. DATE OF building.	death but r EVE D USE OF E 28. (INJURY ay, vbar) FINJURY — etc. (Specify)	DEATH YI PLACE OF DEA At home, term,	In the u	NO [conly one) R: raing Hom WO 1 _ vitory, office	UNC UNC Be 5 Re UURY AT URY AT SPEC 2 Be and place, death occur	ERTAIN sidenca NO and due	8 Other (Sc. 28d. DESCRII 28f. LOCATIOn City or R. 28f. Location to the cause(stime, date and	PERFOR YES 2 weethy) BE NOW IN (Street awn, State)	MED? NO NO NO NUMBER Number ner så stat	CURED r or Rural F	AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO	
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		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	Î	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF OEATH DAY YEAR			TIME OF DEATH	
2, 3 should			SEX 6. AGE (III	n yrs. lest birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATI	E OF BIRTH of th, Day, Year) -24-192!	8.	BIRTHPLA Country) TE	ACE (State or Foreign	
	OR	98. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH N/A										н	
permit, Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY MARYLAND WIC	10c. CIT	Y, TOWH O			list	oury		d. INSIDE CITY LIMITS? YES XXNO			
usit.	COMPLETED BY FUNERAL	100. STREET AND NUMBER 107 EAST LONDON	00. STREET AND NUMBER 107 EAST LONDON AVENUE				ZIP CODE 2180)] 109. CITIZEN				T COUNTRY?	
-0020 Iling physician. the bunal-transit		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? XXVES IF YES, GIVE WAR OR DA	2 NO	1 1	f yes, sp	ecify Cuban, Maxic 2 NO Spec	an, Puerto			American Indian, hita, etc.		
21215 al or attend for use as		15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ION	16e. DECEDENT'S (Give kind of life. Do NOT u	work done of			166. KIND OF BUSINESS/INDUSTRY ELECTRONIC R				PAIR	
YLAND 21 by the hospital or be detached for u	E COM	17. FATHER'S NAME (First, Middle, Last) LAWSON BENJAMII		18. MOTNER'S N LESLI	ER'S NAME (First, Middle, Meidlen Surmarne) SLIE FAUSTINE MISSO								
, MARN be retained the se 5 should a notiffed	TO B	19a. INFORMANT'S NAME (Type/Print) LINDA JOYCE HEN	LINE	19b. MAILING 4010	ROE	SIN	nd Number or Rural HOOD W	AY,	SYKES	VILLE	, M	D. 21784	
BALTIMORE, MARYLAND let death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached had.		20a METNOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remova 4 Donation 5 Other (Secty)	from State GA	PLACE AND DATE	FOR	REST		ANS	OWI		MILL	S,MD.	
BALTIM after death. Page by the funeral directoryal.		22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, SAW GLEN BURNIE, MARYLAND 21061											
hin 24 hours tely filled in b mation, or rea t, the medi		23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrast, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. adult respiratory distress Syndrome The province of the mode of dying, such as cardiac or reapiratory arrast, and a province interval Batween Onset and Death The province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, such as cardiac or reapiratory arrast, and a province of the mode of dying, and a province of the mode of dying, and a province of the mode of dying arrants are a province or a province or a province or a provinc											
P.O. BOX 6876 th certificate be executed ending physician and commit Hygiene prior to burial, or other traumatte ex	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST b. NREUMONI A DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
CORDS res that the digned by the leath and Me vs any Injur	EDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO								AV CC OF	ERE AUTOPSY FINDINGS ARLABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO		
S G Peer R	IAN: M	DID TOBACCO USE CONTRIE		F DEATH Y		_	UNCERTA	IN 🗆			·		
OF VITAL HYSICIAN: The law his certificate has with the State Oep ked, or item 23	PHYSICIAN:	1 YES 2 NO 1	OSPITAL: OTHER: A OTHER: OTHER: A OTHER: OTH						e 8 ☐ Other (Specify)				
	ВУ РН	27. MANNER OF DEATN 1	28a. DATE OF INJURY (Month, Day, Year)	28b. TIR	ME OF JURY M		URY AT PRK? YES 2 NO	28d. Di	EŞCRIBE NOW IN	JURY OCCUR	ED		
ISIC TTENDI TTOR: A after de		3 Suicide 8 Could not be datermined	28s. PLACE OF INJURY building, etc. (Speci	— At homa, larm,	atreet, lect	reet, lectory, office			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
DIV HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours	COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER Mount & Jh	le Resident Physicam AU 4176435 > 12/8/9								onth, Day, Year)		
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) Mansur Shonali University Hospital 22 5.6-een St, Bultinde HD 21201										21201	
	31. DATE FILED (Month, Day, Your) DEC 13 1994 32. HEGISTRAP'S SIGNATURE Jalian Whitelean Randell												

	Follow: The law requires that the death certificate be executed within cours after death. Page 5 may be retained by the hospital or attending physician.	ertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	prior to buriat, cremation, or removal.	, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	neare be executed within fours after death. Page 6	physician and completely filled in by the funeral director	ne prior to burial, cremation, or removal.	er traumatic event, the medical examiner mu	
4	NG PHYSICIAN: The law requires that the death certification	the this certificate has been signed by the attending	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	morked, or item 23 shows any injury, or oth	
and and and	UR ALIENDIN	MRECTOR AT	South de	fem 28 7	
THE STORESTEE	IU INE MUSPITAL	TO THE FUNERAL	be filed within 72	IMPORTANT: It	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPAR CERTIF	RTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH				
	Juanita	Conwa	ıy	Dec. 8,1994	12:30A M				
	4. SOCIAL SECURITY NUMBER 199-18-4973	5. SEX 6. AGE (In yrs. last birthday) 1 — M 2 X F 95 YRS.	IF UNDER 1 YEAR	7. DATE OF BIRTH (Month, Day, Year) 8.	BIRTHPLACE (State or Foreign Country) 5. C.				
OR	MARYKAND GO	WELAL HOSP.	96. CITY, TOWN OR LOCATION OF D	GALULAND 9c. COUNTY	Y OF DEATH				
DIRECTOR	10a. STATE 10b. COUNTY	10c. CI	TY, TOWN OR LOCATION	Pa	10d. INSIDE CITY				
	10e. STREET AND NUMBER		101. ZIF CODE	10g. CITIZE	1 YES 2 ND N OF WHAT COUNTRY?				
FUNERAL	1620 N. 55	STREET	1913	39 U	1,5,A.				
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR DR OATES	13. WAS DECENDENT DF NISPA If yea, specify Cuban, Maxico 1 YES 2 ND Specify		I. RACE — American Indian, Black, White, atc.				
D BY	Widowed 4 Divorced 15. DECEDENT'S EDUC		USUAL OCCUPATION	OLACK					
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+) College (1-4 or 5+)	work done during most of working	16b. KIND OF BUSINESS/INDUS	STRY				
MP		DENING	MACHINE UPEC.	MANUFAC	TURING				
8	17. FATHER'S NAME (First, Middle, Last)	Remoder	16. MOTHER'S NA	ME (First, Middle, Maiden Surname)					
BE	LAURENCE	DONA PARIE	J058	PHINE BONAD	ARTE				
5	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Rouse Number, City or Town, State, Exp. Code) 2524 WE CULL OH ST. BALTO, MA 31219								
	20a. METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	20b. PLACE AND DATE cemetery, crematory or of	OF DISPOSITION (Name of phase place)	OATE, 20c. LOCATION — CIT	y or Town, Stata				
	21. SIGNATURE OF FUNEBAL SERVICE LICE	LITAE V	22. NAME AND ADDRESS OF E	ICILITY OF A	MY				
	· 7000	Drouw	1206 W. NON	. BROWN COULL	INITY FIF				
	23. PART I. Enter the diseases, or contains abook, or heart failure. L	omplications that caused the death. Do list only one cause on each line.	not antar tha moda of dying, aud	h as cardiac or respiratory arres	t, Approximata interval Batween				
	IMMEDIATE CAUSE (Final				Onset and Death				
	disease or condition resulting in death) a. Cancer of the Colon DUE TO (OR AS A CONSEDUENCE OF):								
z									
AT 10	Sequantially list conditions, if any, leading to immediata DUE TO (OR AS A CONSEDUENCE OF):								
FIC	cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated evants	DUE TO (OR AS A CONSEQUENCE D	F):						
CERTIFICATION	resulting in death) LAST								
AL C	PART II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in		24b. WERE AUTOPSY FINDINGS				
DIC				PERFORMED? 1 TYES 2 XND	AMILABLE PRIOR TO COMPLETION DF CAUSE DF DEATN?				
BY PHYSICIAN: MEDIC	DID TOPACCO LIST CONTR	DIRITE TO CALISE OF BEATH W			1 - YES 2 - NO				
AN	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE OF DEATH YI		N L]					
Sici	EXAMINER?	HOSPITAL: 1 □Xnpetient 2 □ ER/Outpatient 3 □ DOA	OTHER:						
ЖH	27. MANNER OF DEATN	28a. DATE OF INJURY 28b. TIN		28d. DESCRIBE HOW INJURY OCCUP	RED				
34	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Hear)	JURY WORK? M 1 YES 2 NO						
	3 Suicide S Could not be determined	28a. PLACE OF INJURY — At home, larm, building, etc. (Specify)	street, lactory, office	281. LOCATION (Street and Number or City or Town, State)	Rural Route Number,				
4	290. CERTIFIER 1 XCERTIFYING PHYSIC	IAN: To the best of my knowledge, death occurr	ad at the time date and place and due	to the equation and manner or stated					
COMPL	(Check only one) 2 MEOICAL EXAMINER	: Dn the basis of examination and/or investigation	on, in my opinion, desth occured st the	time, date and place, end dua to the c	ause(a) and manner ae stated.				
BE	29b. SIGNATURE AND THE OF CERTIFIER	esman Med	29c. LICENSE NUI		IGNED (Month, Day, Year) 12-08-94				
2	30. NAME AND ADDRESS OF PERSON WHO	CDMPLETEO CAUSE DF OEATN (ITEM 27) (Type	, Print)						
		sman, M.D. c/o	Maryland Gen	eral Hospital					
	DEC1 3 1994	C. Daniel Review							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

									A M	30100
	FOR	STATE OF M	ARYLAND /	DEPARTM	ENT OF I	JEAITH	AND M	IENTAL HYGIEN	IE	
	1 - STATE REGISTRAR	OINIE OI III		ERTIFICA				REG. NO		
	1. OECEDENT'S NAME (First, Middle, Last)								MY	YEAR 3. TIME OF DEATH
	Nathaniel B. Cole 4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les	et hirthriau) IE I	INDER 1 YEAR	IF UNDER	24 MDC	12 1	.1	94 12:35 p M B. BIRTHPLACE (State or Foreign
	220-05-5367	1 M 2 F	8	YRS. MON		HOURS	MIN.	(Month, Day, Year)	14)	Country)
	9a. FACILITY NAME (If not institution, give stre	et and number)	1 ,	9b.	CITY, TOWN	OR LOCATIO	ON OF OEAT	TH 17	9c. COUNT	Y OF DEATH
OR		ration H	ospital		Ba	Mim	ove			
DIRECTOR	10a. STATE 10b. COUNTY		7	10c, CITY, TO	WN OR LOCA					10d. INSIDE CITY
DIR	Maryland			R	altim	the.				LIMITS?
MI	10e. STREET AND NUMBER	A			10	. ZIP CODE	E		10g. CITIZE	EN OF WHAT COUNTRY?
FUNERAL	3706 Nongwk	aveni	The same of the sa			21		7		USA
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 1	RMED NO	If yes, sp	ecity Cuba	n, Mexican,	C ORIGIN? (Specify Ye Puerlo Ricen, etc.)	a or No— 1	4. RACE — American Indian, Black, White, etc.
ВУ	3 Widowed 4 Divorced	WWI	1943-	1945	1 YES	2 NO	Specify:			Black:
TED	15. DECEDENT'S EDUCA (Specify only highest grade of		/G	CEDENT'S USU	done during m	ON ost of workin	ng	16b. KIND OF BL	ISINESS/INDU	STRY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	-17	DO NOT USO FOR	1	.0-	_	Tuo	ne nav	44:
OMI	12 FATHER'S NAME (First, Middle, Melden Su 18. MOTHER'S NAME (First, Middle, Melden Su								Jarion	
ш	Sam Vous					Co		moe	Mad	den
TO B	194. INFORMANT'S NAME CONSTRUCT	1 0	19	b. MAILING ADD	RESS (Street	and Number		oute Number, City or Tox	vn, State, Zip C	Code)
_	Marquenia Cos	tello	11	1.0. ROK	38511		atto	No 21	207	- 8511
	20es METHOD OF DISPOSITION 1 De Burlai 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	rel from State	gern tery, cre	AND DATE OF DIS emetory or other p	lace	- 1	12/	DATE 20c. LC	CATION — CI	fy or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE A	loar	tison	22 NAME A		SS OF FACI	190 10 W	ings	MI IIS, MA
	Dozonk	8.	All	(1)	Jose	eph	Li	TUSS 7	D	at HM
	23. PART/I. Enter the diseases, or co	implications that	caused the de	nath. Do not e	nter the mo	de of dyl	ing, auch	ea cardiac or rees	lratory erre	st, Approximata
	shock, or heart failure. Li iMMEDIATE CAUSE (Finel	st only one caus	se on each line				3,		99	Interval Batween Onsat and Death
	diaeese or condition reaulting in death) e.	_ TN	RUM	ONIA	>					Teu days
	- 1/2	DUE TO (OR AS A CONSE	OUENCE OF):						
0 N	Sequentially list conditions, b.	DUE TO (OR AS A CONSE	OUENCE OF:						
ERTIFICATION	If any, leading to immediate ceuse. Enter UNDERLYING	100		26-107- 57-4						
Ī	CAUSE (Disease or Injury that Initiated evants	DUE TO (OR AS A CONSE	OUENCE OF):						
CER	resulting in deeth) LAST									
	PART il. Other significant conditione	contributing to	death but not r	resulting in th	e underlyin	g cause g	given in Pa			24b. WERE AUTOPSY FINDINGS
MEDICAL								PERFO	2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
								_	, ,	1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CO	ONTRIBUTE	TO CAUS	SE OF DI			NO	Ø		
SICI	EXAMINER?	HOSPITAL:	ED/Outpetlest 2		HER:		EATH (Checi	15-61-1-1-1-1		
Ήχ	27. MANNER OF DEATH	28a. DATE OF I	INJURY	28b. TIME OF	28c. IN.	JURY AT		Other (Specify) 28d. DESCRIBE HOW	INJURY OCCU	PRED
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day	y, rear)	INJURY		ORK? YES 2	NO			
8	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF building, e	INJURY — At ho etc. (Specify)	ome, farm, street	, factory, offic	CON .	1	281. LOCATION (Street City or Town, State		r Rural Route Number,
	20. CERTIFIED \/									
COMPL	29e. CERTIFIER (Check only one) CERTIFYING PHYSICI CERTIFYING PHYSICI MEDICAL EXAMINED									
	296. SIGNATURE AND TITLE OF CERTIFIER	On the bests of the		investigation, In	my opinion, (ceuse(s) and manner as stated.
H	michael 1/	Vind)	s.Do	Na. 17	,	29c. LICE	ENSE NUMB	BER	N .	SIGNED (Month, Day, Year)
2	The same of the sa	0000	4010	ININ		L			12	- //// /7

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S CONSTURE

Michael V. Woodbridge, M.D.

3 1994

31. DATE ELER (M.

21201

10 N. Green St. Balto., MD

n Yes DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	n 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
HE HOSPITAL OR AT	HE FUNERAL DIRECT	led within 72 hours at	ORTANT: If item 2
2	2	8	Σ

PHYSICIAN:

ВY

COMPLETED

BE

2

94 36701 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Dec 10 1994 GRACE CARTER MAE 1:24 am 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPI ACE (State or Foreign (Month, Day, Year) 43 1 M 2-VIRGINIA 212-44-5799 51 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Hospital Baltimore Towson, Maryland 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD BALTIMORE 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 410 ATHOL ASVE APT. B 21229 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11 MARITAI STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-14. RACE — American Indian, Black, White, alc. If yea, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify BLACK BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY Secondary (0-12) College (1-4 or 5+) 9th MANAGER OF MURRAY'S 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JAMES CARTER ROSA PERRY BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 410 athol AVE. BALTO. MD. 21229 CHAUNCEY ASKINS 20a. METHOD OF DISPOSITION
12. Burlal 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE WESTERN STAR CEM. 12-14-94 4 Donation 5 Other (Specify) BALT (MORE, MD. 21. SIGNATURE OF FUNERAL SEBUJCE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR ST. 21217 23 JART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) CORONARY ARTERY DISEASE UNKN QUE TO (OR AS A CONSEQUENCE OF b. DIABETES MELLTUS
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION **UNKN** Sequantially list conditions, if any, leading to immediate . Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE

1 - YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

OF DEATH? 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

26. PLACE OF DEATH (Check only one) HOSPITAL:
1) Inpetient 2 ER/Outpetient 3 DOA OTHER

28a. DATE OF INJURY 28b. TIME OF INJURY

4 ☐ Nursing Homa 5 ☐ Realdence 6 ☐ Other (Specify)

28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED

als of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated.

М 1 YES 2 NO 28e. PLACE OF INJURY — At home, lerm, street, factory, offica building, atc. (Specify)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

5 Pending Investigation

6 Could not be

determined

2 MEDICAL EXAMINER: On the

29c. LICENSE NUMBER 45643

29d, DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR MARK KELEMEN 7620 YORK ROAD TOWSON, MD 21204

1 TES 2 700

27. MANNER OF DEATH

Netural

Accident

3 Sulcide

4 Homicide

(Check only one)

REGISTRAR'S SIGNATURE

AMERICAN

Approximata Intarval Between **Onset and Death**

WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 | YES 2 | NO

ITEMS: 11,17,19a, PER F.H. FILM G-718 12/13/94 t.t

	1 - FOR STATE REGISTRAR	. 11,17	STATE OF	MARYLAND) / DEPAF	RTMENT	OF H	EALTH AND	D ME	NTAL HYGIEN			
- 5	1. DECEDENT'S NAME (First	, Middle, Last)							2	DATE OF DEATH			3. TIME OF DEATH
	Wallace				Ca	nn				MONTH Dec 08	AY 1.9	94	2305
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.		IF UNDER 1		IF UNDER 24 HR	RS. 7	DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign
	220-09-41	.25	1 🕅 🟋 2 🗆 F	84	YRS.	MONTHS	DAYS	HOURS MIN	N.	(Month, Day, Year) AUG. 26	-10	Count MA	m RYLAND
	9e. FACILITY NAME (If not in	stitution, give	street end number)			9b. CITY,	TOWN (R LOCATION OF				NTY OF D	PEATH
OR	519 N. MO	ount	Street			Ba	1+-	imore		CITY	NC	NE	
בו	RESIDENCE OF DEC	10b. COUNT			1 40- 017	Y, TOWN OF							
DIRECTOR	MARYLAND		IONE		ipe. Cit			IMORE	СТ	mv			10d, INSIDE CITY LIMITS?
	10e. STREET AND NUMBER		ONE			DF		ZIP CODE	CI	11			14 YES 2 NO
RA	519 N. M		Cubrru				101	21.223	2	100			STATES
FUNERAL	11. MARITAL STATUS	OONI	12. WAS DECEDEN	IT EVED IN II S						00100100 0011 11			
	1 Never Merried 2 Merried FORCES? 1 YES			YES X	□ NA	16	yes, sp	ecify Cuben, Me:	xicen, F	verto Rican, atc.)		Blac	E — Americe <i>n</i> Indian, k, White, etc.
В	3 XWidowed 4 Divorced					1 □ YES 2 □ NO Specify: AFRICAN AM					AMERICA		
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16e.	DECEDENT'S	USUAL OC	UPATIO	ON		16b. KIND OF BU			
Щ	Elementery/Secondary (0-12) Cottege (1-4 or 5+)			+)	(Give kind of life. Do NOT u	se retired.)	inng mo	st of working		BALTI	MORE	CI	TY
MP	2ND NONE				LAE	ABORER water departmen					ment		
COMPLETED	17. FATHER'S NAME (First, Middle, Last) EDDIE 16. MOTHER'S NAME (First, Middle, Maiden S.						Sumame)	· -					
BE	EDDIE THORNTON AMANDA CANN												
2	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 GUILFORD AVE. BALTO, MD. 21218												
	1 Buriel 2 Cremetic	n 3 🗌 Ham	ovel from State							DATE 20c. LO	CATION -	City or To	own, State
	4 Donetion S Other 21. SIGNATURE OF FUNERA		CENTER	GRE	EEN M					12/10/9			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213												
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest. Approximate												
ı	anock, or heart failure. List only one cause on each line.									Interval Betwee			
	disease or condition resulting in death) a. Attensiclentic Cerciorgala Deservi												
	resulting in death)	•	DUE TO	(OR AS A CON	SEOUENCE O		0-0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		noen		<u>.</u>	
z													
CERTIFICATION	Sequentially list conditi if any, leading to imme	dieta	DUE TO	(OR AS A CON	SEOUENCE O	F):							
5	cause. Enter UNDERLYI CAUSE (Disease or Inju		c										
E	that initieted events resulting in death) LAS		DUE TO	(OR AS A CON	SEOUENCE O	F):							
5			d										
AL (PART II. Other algnifica	nt condition	a contributing to	death but no	t resulting	In the und	erlying	cause given	In Par			24b	. WERE AUTOPSY FINDING
할										PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä										1	A	,	DF DEATH?
ä	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF DI	EATH YE	S 🗆 N	0 [UNCERTA	AIN	- mon	ellen	7	
SIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		26. PI	LACE OF DEA		ly one)						
SIG	1 X YES 2 □ NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:	ng Horn	5 X Reelden	ce 6	Other (Specify)			
PHYSICIAN: MEDIC	27. MANNER OF DEATH	51.51	26e. DATE OF (Month, D	INJURY Pay, Year)	26b. TIM	E OF 2	ac. INJI	URY AT	26	d. DEŞCRIBE HOW I	NJURY OC	CURED	
B⊀		Pending Investigation				М		ES 2 NO					
		Could not be	28e. PLACE O building,	otc. (Specify)	home, farm,	rtreet, fector	y, office		26	f. LOCATION (Street a	and Number	or Rural F	Route Number,
	4 Homicide	determined				ony or rown, Grandy							
COMPLETED	29e, CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.												
S S	one) 2 MEDI	CAL EXAMINE	R: On the bests of s	xamination end/	or investigation	n, in my op	nton, de	eath occured at 1	the tim	, date end place, en	d due to th	e cause(e) end manner se stated.
BE C	296. SIGNATURE AND TITLE	OF CERTIFIE	11 11	-	-		П	25c, LICENSE N	NUMBE	1	29d. DAT	E SIGNED	(Month, Day, Year)
60	1 11.0 0	50	II TH		1								

Baltimore.

Penn Street.

REGISTRAR'S SUPATURE

1994

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BALTIMORE, MARYLAND 21215-0020

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notified at once.

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or other traumatic event, the medical examiner must

PHYSICIAN: MEDICAL CERTIFICATION

BY

COMPLETED

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disease or condition_

Sequantially list conditions,

DEC1 3 1994

resulting in death)

or removal

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OF ALEXAINNO PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNITEAL INFOCATE After this certificate has been signed by the attending physician and complete be filed within 22 nouns any full the State Dept, of Health and Mental Hygiene prior to burial, crems IMPORTAND. If

	REGISTRAR 1. DECEDENT'S NAME (First, Middle, List)	/	CE	KIII	CATE	. OF	DEATH	REG. NO.			3. TIME OF DEATH	
	ISADORE CHANIN	<u> </u>							6. 1	994	7:05 P	М
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE 183-01-0262 F			birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV. 7. 19	06	Count	HPLACE (State or Foreign ry) 1551a	
	9s. FACILITY NAME (If not Institution, give s	9s. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						\neg
TOR	Montgomery General Hospital				Olney			N	Montgomery			
DIRECTOR	100. STATE 10b. COUNT New Jersey Atla			Atlantic City						10d. INSIDE CITY LIMITS? 1 TYPES 2 NO	٦	
AL	10e. STREET AND NUMBER					101.	ZIP CODE	CODE 10g.			WHAT COUNTRY?	⊣
EB	35 S. Virginia Avenue						08401			USA		
D BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 XWidowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 FORCES? 1 FYES, GIVE WAR OR DATES			2 No If yes, specify Cuben, Mexican, Puerto Ricci 1 YES 2 NO Specify:			nn, Puerto Rican, etc.)	or No-	14. RAC Blec Spec	E — American Indien, k, White, etc.		
Ħ	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G/s	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work does during most of working life. Do NOT use retired.) Upholsterer			16b. KIND OF BUS	INESS/IN	DUSTRY			
COMPLETED	Elementary/Secondary (0-12) 12 Yrs	College (1-4 or 5+)						Furniture				
Ö	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S N	ME (First, Middle, Maiden	Surname)			
BE (Samuel Chanin						Soni	a (Unascert	iana	able)		_
2	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS	(Street e	nd Number or Rural	Route Number, City or Town	n, State, Zij	Code)		
-	Robert Lewis Cha	anin	1	8604	Her	tiag	ge Hills	Drive, Bro	okev	7 1 116	e, MD 20833	
	20e. METHOD OF DISPOSITION 13CPBurlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	ob. PLACE A emetery, crem Mount	natory or oth	r DISPOSI Per place)	Ceme	me of etery 11	/29/94 Spr	ingf	city or To	own, State Township.	H
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stottlem			ount Sharon Cemetery 11/29/94 Springfield Township 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL ST, NW, WASHINGTON, DC 20012								

if any, leading to immediate cause. Entar UNDERLYING F CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events FUCE PHANO resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MALERIENGION 1 YES 2 NO OF DEATH? 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗌 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only or HOSPITAL:
1 Glopatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident М 1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, factory, office building. atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the besis of examination end/or trivestigation, in my optnion, death occured at the time, date end piece, and due to the ceuse(e) and manner ee stated.

YOH 2

29c. LICENSE NUMBER

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UBUTRICULAR FIPERUMION - REAPIROTY

CHORILE HOLL PUE TO (OR AS A CONSEQUENCE OF):

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

12792

29d. DATE SIGNED (Month, Day,

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24 4000

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TABLE TO SEE THESE SEE REVISE ON THE THEO OF CONFESSIONS

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withh. Yours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTMENT CERTIFICATE		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest) BERNICE	В.	COHEN		2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH 4:15P M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday) IF UNDER	1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		RTHPLACE (State or Foreign		
	212 58 2345	1 D M 2 D F 7 4	YRS, MONTHS	DAYS HOURS MIN.	3-11-19	Coo	w York		
_	9a. FACILITY NAME (If not institution, give stre			TOWN OR LOCATION OF D		9c. COUNTY OF			
DIRECTOR	House of Pines	s-Meridian	E	aston		Talbo	t Co		
H	10a. STATE 10b. COUNTY		10c. CITY, TOWN C	R LOCATION			10d. INSIDE CITY LIMITS?		
		bot Co	Oxford	<u> </u>			1 YES 2 NO		
FUNERAL	10e. STREET AND NUMBER			101. ZIP COOE	,	10g. CITIZEN O	F WHAT COUNTRY?		
当	800 S. Morris	Street	_1 436	2165	4		USA		
	11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE — A.								
BY	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 1 YES 2 NO Specify:								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KINO OF BUSINESS/INOUSTRY								
ا ت	Elementary/Secondary (0-12) College (1-4 or 5 +) Iffe. Do NOT use retired.)								
N N	12+ 4 Homemaker								
	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Meiden	,	,		
BE	Hilary O. Brashear Rose Jeannette Colliso								
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	Gerald Cohen 800 S. Morris St. Oxford, MD21654								
	20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Remov		LACE AND DATE OF DISPOS ery, cremetory or other piece)	TION (Name of	OATE 20c. LO	CATION City or	Town, State		
	4 Donation 5 Other (Specify)								
- 1	21. SIGNATURE OF PINERAL SERVICE LICE	Ronald Wa		NAME AND ADDRESS OF FA	State A	Anatomy	y Board		
	111/10001111	Mel 1 12	1494	55W.Balti	more St,	Balto, N	MD21201		
	23. PART I. Enter the diseases, or co	mplications that caused t	he daeth. Do not antar	tha moda of dying, aud	ch as cardiac or reap	retory arreat.	Approximate		
- 1	ahock, or heart fellure. Li	at only one cause on eac	h line.				Interval Between Onset and Death		
	disease or condition / / /								
	resulting in death) a								
-	- A · Gb								
<u>Ö</u>	Sequentially list conditions, if any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):								
₹ I	cause. Enter UNDERLYING								
	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF):						
CERTIFICATION	reaulting in daeth) LAST								
	DATE II Other significant conditions								
ÄL	PART II. Other algnificent conditiona	contributing to death but	not resulting in the un	dariying cause givan In	Part I. 24a. WAS AN		46. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă	MAS MAL MAN	a siso m	in to d	int	1 YES 2	□ NO	COMPLETION OF CAUSE OF DEATH?		
M							1 YES 2 NO		
PHYSICIAN: MEDIC									
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26 PLACE OF OEATH (C	heck only one)				
Š		□ Inpetient 2 □ ER/Outpeti	lent 3 DOA 4 Nun	f: ling Home 5 ☐ Residence	8 Other (Specify)				
£	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	26d. OESCRIBE HOW I	NJURY OCCURED			
BY	1 Natural 5 Pending 2 Accident Investigation	,	M	1 YES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF INJURY — building, atc. (Specify,	At home, farm, street, fact	ory, office	281. LOCATION (Street	and Number or Run	al Route Number,		
=	4 Homicide determined	Danieling, and Topochy,	,		City or Town, State)				
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICI	AN: Yo the best of my knowled	loe, death occurred at the ti	me date and place, and du	to the cause/s) and ma	oner se stated			
Ĭ.		On the beels of examination a					se(e) and manner as stated.		
BE	(WN)	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month							
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF SEA	H ATEM AT AT A SA						
					-				
	DR RICHARD B		607 Dutch	nan's Lane	e,Easton,	MD 21	601		
	31. DATE FILE DEC 13 1994	32 ABGISTRAB'S SIGNAT	Karlell						

1651 - 230

Cinal d

MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
Philip Lim, M) Mercy Medica

intern

REGISTRAR'S SIGNATURE

Lin

Philip

31. DATE FILED (Month, Day,

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

		7	A. A.		94 36/03		
FOR 1 STATE	STATE OF MARYLA	ND / DEPARTM	ENT OF HEALTH AND	MENTAL HYGIEN	F.		
REGISTRAR			ATE OF DEATH	REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)		Davis		2. DATE OF OEATH DA			
	5. SEX 6. AGE (II	yrs. last birthday) IF)	12	08 94 12:500		
220-01-4121	1 × M 2 0 F 7	5 YRS. MON	UNDER 1 YEAR IF UNDER 24 HRS ITHS DAYS HOURS MIN.	06/09/1	9 S. CAROLINA		
9a. FACILITY NAME (If not institution, give str Mercy Medical Cente			Baltimore, Mi		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CITY TO	WN OR LOCATION		404 BIGIDE OUT		
MARYLAND 100. STREET AND NUMBER	n/a		BALTIMORE Ha	nover	10d. INSIDE CITY V LIMITS? TY YES 2 NO		
	ROAD		101. ZIP CODE 21076		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	U.S. ARMED 2 NO	13. WAS DECENDENT OF HISP If yes, specify Cuban, Mex 1 YES 2 NO Spe	ican, Puerto Rican, atc.)	or No— 14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EQUCA (Specify only highest grade of Elementary/Secondary (0-12)		16a. DECEDENT'S USU (Give kind of work itte. Do NOT use ret LABOREF	done during most of working fred.)	BETHLEHI			
17. FATHER'S NAME (First, Middle, Lest) GEORGE DAVI	S		MAMI				
19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE HARRISON 7904 S. CARTIER COURT, SEVERN, MD 21144							
20s. METHOD OF DISPOSITION 1 X Journal 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Cempetary as other place) AMAYLAND 20c. LOCATION — City or Town, State MEADOWRIDGE CEMETERY 12-13 LAUREL, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AND ADDRESS OF	FACILITY			
Deman D	Johnson				. NORTH AVENUE		
23. PART I. Enter the diseases, or co shock, or heart failure. Li	mpilcations that caused st Dnly Dna causa Dn aa	tha death. Do not e ch lina.	entar tha moda of dying, s	uch as cardiac or reaple	ratory arreat, Approximata intervsi Batwe		
IMMEDIATE CAUSE (Final disease or condition		At the control of the					
reaulting in dasth) a.	myocar	ouero (or as a consequence or):					
	i		•		24 hou 2 year		
Sequantially list conditions, b.	DUE TO OR AS A	CONSEQUENCE OF):			7 7 00		
If any, leading to immediata cause. Enter UNDERLYING		A	1 luna ca	nlar	2 year		
CAUSE (Disesse or injury that initiated events	Sq Vam	CONSEQUENCE DF):	l long ca	vid.			
resulting in death) LAST d.							
PART II. Other significent conditions	contributing to death hu	t not resulting in th	e underlying cause given	n Part i. 244 WAS AN	AUTOPSY 24b. WERE AUTOPST FINDING		
hupertension			o and anything cause given	PERFORI			
diahetes mel	1			- Xes	OF DEATH?		
DID TOBACCO USE CONTRI	- 1 - 0	DEATH YES	□ NO □ UNCERTA	IN [/NUS	8 Dec C 10 Yes 2 Yes		
25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH (C			114 /		
	HOSPITAL:		HER: Nursing Home 5 - Rasidenc	a 8 ☐ Other (Specify)	1000		
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCURED		
1 Netural 5 Pending 2 Accident Investigation	(11101111, 00), 1041/	, moont	M 1 YES 2 NO				
3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY - building, atc. (Specif	At home, farm, street	, factory, office	28t. LOCATION (Street a: City or Town, State)	nd Number or Rural Route Number,		
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	AN: To the best of my knowle	dge, death occurred at	the time, date and place, and d	ue to the cause(a) and man	ner as stated.		
					d due to the cause(e) and manner as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE N	UMBER	29d. DATE SIGNED (Month, Day, Year)		

PO 8180

Medical Center

29d. DATE SIGNED (Month, Day, Year)

301 St. Paul Place, Baltimore, Mi

12/8/94

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	FOR STATE	PER F.H.	STATE OF MA	T OF HEALTH AND MENTAL	HYGIENE
-	REGISTRAR			E OF DEATH	REG. NO.

_	TIEGIOTIBUT		OLITTII I	DAIL OF	DEATH	HEG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) JAMES C DRA	KE				2. DATE OF DEATH MONTH D	YEAT	
	3111100 01					12 8		
	4. SOCIAL SECURITY NUMBER 5. S	6. AGE (In yrs	den //	IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		ATTUCK
	9s. FACILITY NAME (If not institution, give street as	nd number)	10	9b. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY O	F DEATH
5	Harbar Hose	21/21		130	timore			V.
1 5 1	RESIDENCE OF DECEDENT	114		100	HIMONE			
DIRECTOR	10e. STATE 10b. COUNTY			TOWN OR LOCATI				10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER			Battimo	re		T	1 YES 2 NO
FUNERAL	42 Waldon O	ak Cour	-		2120 T	7		S A
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1/X YES 1.000					IIC ORIGIN? (Specify Yes		ACE — American Indian,
	1 Never Married 2 Merried 3 Wildowed 4 Divorced	YES, GIVE WAR OR DATES		π yes, spe	2 NO Specify	n, Puerto Rican, etc.)		lack, White, etc.
BY	3 Widowed & Dy Divorced	Concelor					/:	310.46
8	15. DECEDENT'S EDUCATION (Specify only highest grade complete)		(Give kind of wo	SUAL OCCUPATIO	N st of working	166. KIND OF BUS	SINESS/INDUSTR	Y
	Elementary/Secondary (0-12) Col	liege (1-4 or 5+)	life. Do NOT use	retired.)	4000000	11	1.1	
COMPL	12	2	Counc	ebr		10	sprial	
-	17. FATHER'S NAME (First, Middle, Last)	Diska			4	ME (First, Middle, Marden	Surname)	
BE	JATTHES Calvin	Drake			10	0	mas	
٩	Mariam White		42 U	A GU	nd Number of Rural I	Route Number, City or Tow	n, Stere, Zip Code)	L 21207
	20e_METHOD OF OISPOSITION 11 Burlel 2 Cremetion 3 Removat for the Donetion 8 Other (Specify)	rom State 20b. PLA	rematory of	DISPOSITION (National place)	me of	1 / 1 / 1	CATION -ADAM	S, TENNESSEE
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E I/E J	To Car		D ADDRESS OF FA		111011) -1	
	Joseph L.	Russ		JOSE	641.	Ross FL	1 222	22 Whorth
	23. PART I. Enter the diseasea, or comp	lications that caused the	deeth. Do no			h aa cardiac or respi	ratory arrest,	Approximate
	ehock, or heart fellure. List of IMMEDIATE CAUSE (Final	only one ceuse on each	line.	/		/		Interval Between Onset and Death
1 1	diseese or condition	ARNOLD CH	IARI	SYNDRO	ME			1
	DUE TO (OR AS A CONSEQUENCE OF):							
2								
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):							
2	CAUSE (Disease or injury							
ᄩ	that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF):					
	reaulting in deeth) LAST							
	PART ii. Other significant conditions con	ntributing to deeth but r	not requiting in	the underlying	cause alven in	Part i. 24s. WAS AN	AUTOREV	24b. WERE AUTOPSY FINDINGS
DICAL	ASPIRATION PN	EUMONIA	ot recounting in	the dribbillying	Cudae given in	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ă	TRACHEAL BLEET					1 _ YES 2	□ NO	OF DEATH?
Σ			IIIOE OF	D.E.A.E.I. 34	FC - 110			1 TES 2 NO
Z	DID TOBACCO USE CON	AIRIBUIE 10 CA	AUSE OF					
PHYSICIAN		SPITAL:	-	28. PL OTHER:	ACE OF DEATH (Ch	eck only one)		
ΥS		Inpatient 2 ER/Outpatier				8 Other (Specify)		
	27. MANNER OF DEATH 1 Neturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	RK?	28d. DESCRIBE HOW t	NJURY OCCURED	•
B	2 Accident Investigation				ES 2 NO			
8	3 Suicide 8 Could not be	28e. PLACE OF INJURY — A building, atc. (Specify)	At home, tarm, atr	reet, factory, office	'	28t. LOCATION (Street of City or Town, State)		ral Route Number,
E								
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICIAN:	To the best of my knowledge	e, death occurred	at the time, date	end place, end due	to the cause(e) end mar	nner es stated.	
S S	one) 2 MEDICAL EXAMINER: On	the beele of examination and	d/or investigation,	, in my opinion, de	eath occured at the	time, date and place, en	d due to the ceu	se(e) end menner se stated.
w l	29b. SIGNATURE AND TITLE OF CERTIFIER		0.5.1		29c. LICENSE NUI		29d. DATE SIGN	NED (Month, Day, Year)
EUGENIO F VINES MD. WILL AS 244161430								8 94
2	30. NAME AND ADDRESS OF PERSON WHO CO							
	EUGENIO F VINES			HANOV	ER STRE	ET BALT	imore	, MD,
	31. DATDEC 1301994	32 PASIBLES PROPERTY	tell,					
1 1	DEOT 0 1334 / 1							

I am - I for East 2 a.

BALTIMORE, MARYLAND 21215-0020	rSJCIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	IN THE HIGH ME OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO WE FLANERAL INTECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun be two flowers after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

_	REGISTRAR			ERIIF.	CAIL	UF	DEAL	п		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH	ν	YEAR	3. TIME OF OEATH
	MILTON	Α.		DEF	OFR				mONT!	Dec 1			11:50.pm M
	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. la		IF UNDER 1		IF UNDER 2			OF BIRTH		a, BIRTH	IPLACE (State or Foreign
	217-30-2697	1 💢 M 2 🗆 F	61	YRS.	MONTHS	DAYS	HOURS	MIN.	8/2	1/193	33	Mar	y 1and
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, T	TOWN 0	R LOCATIO	N OF DEA				NTY OF D	
œ													
K	RESIDENCE OF DECEDENCE	pitel				Tox	vson,	Many	rland.			Balt	more
DIRECTOR	10e. STATE 10b. COUNTY	1		10c. CIT	, TOWN OR	LOCAT	ION						10d. INSIDE CITY
	Maryland			Ba	lto.	Cit	y, Mo	d.					LIMITS?
	10e. STREET AND NUMBER					_	ZIP COOE				10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	1625	Jackson	n St.				2.	1230)		IIni	ted	States
ξ	11. MARITAL STATUS	12. WAS DECEDENT		RMED	13 W	AS DEC				? (Specify Yes			E — American Indian,
	1 Never Merried 2 Merried	FORCES? 1 []	YYES 2		11 1	yes, spe	cify Cuben	, Mexican	, Puerto f	lican, etc.)	01 110-	Black	k, White, etc.
2	3 Widowed 4 X Divorced	Korean	H OH DAIES		11	TES	2 XNO	Specify:				Speci	"White
2	15. DECEDENT'S EDU	CATION	18e. D	ECEDENT'S	USUAL OCC	UPATIO	N		16b.	KINO OF BUS	INESS/IN	DUSTRY	
COMPLEIED	(Specify only highest grade Elementery/Secondary (0-12)	College (1-4 or 5+)	(C	Give kind of v e. Do NOT us	rork done du e retired.)	ring mos	st of working	7	1000				ł
۲	12th.Grade	2		Fire	eman					Balto	.Ci	ty,	Fire Dept.
5	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAM		Aiddle, Maiden			
		Archiba	1 d M 1	DoBo	2 12			aise		Ε.	,	ice	
씲	19e. INFORMANT'S NAME (Type/Print)	AI CHIDA.				Steened or			_	E •			
2	Charlotte E.Wo	aniak	- 1										.21090
	20e. METHOD OF DISPOSITION	ZHIAK	Lank BLAGE	ANDDATE				rb v		T		_	
	1 → Buriel 2 □ Cremetion 3 □ Rem	oval from State	cemetery, cr	emetary or of	her place)			-	DAT			City or To	
	4 1 Donation 5 Other (Specify)	ENGEE	I Dula	aney			Men Men			/14 E			
	II. SIGNATURE STATES SERVICE SC	1	1		22. NJ	AME AN	D ADDRES	S OF FAC	ILITY	Balto	.Md	. 2	1230
	Albred (4. 7/0ml	10		Mo	cCu	11y	Fun	era	1 Hon	ne,1	30	E. Fort Ave.
CERTIFICATION	shock, pr heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	* MULTIRLE * SEPSIS (0	FAORGA	EQUENCE OF	7):	SYN	DRON	Æ					intarval Between Onset and Death
=	that initiated events resulting in death) LAST				,								1
5		0.											
A.	PART II. Other significant condition	s contributing to d	eath but not	resulting i	n the und	erlying	cause gl	Ivan In P	Part i.	24a. WAS AN		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL										1 YES 2			COMPLETION OF CAUSE OF DEATH?
N N											X		1 TYES 2 NO
									_				X
SICIAN	25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF DE	ATH (Chec	ck only on	e)			
	EXAMINER? 1 YES 2 NO	HOSPITAL:	R/Outpatient	3 DOA	OTHER:	na Home	5 Red	eldence 6	Othe	(Specify)			
	27. MANNER OF DRAIN	80. DATE OF IN	JURY	26b. TIM	E OF 2	8c. INJI	JRY AT			CRIBE HOW IF	JURY OC	CUREO	
	1 Natural 5 Pending	(Month, Day,	Year)	INJ	URY M	1 Y	RK? 'ES 2 🗌	NO					
0	3 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF	INJURY — At h	ome, ferm, s	treet, factor				28f. LOC	ATION (Street e	nd Numbe	r or Rumi i	Soute Number
9	4 Homicide 6 Could not be	building, et	c. (Specify)			,		ı	City	or Town, State)			Tours Trainess,
4	29e. CERTIFIER		_						_				
COMPLEIED	(Check only one) 1 GPHTIFYING PHYSI one) 2 MEDICAL EXAMINE	CIAN: To the best of m											CONTRACTOR STATE
3			mination end/or	mvestigatio	n, in my opi	mon, o	stn occure	ed at the ti	ime, date	end piece, en	due to t	he couse(e) end menner ee stated.
H H	29b. SIGNATURE AND TITLE OF CERTIFIES	- M	21				29c. LICE	NSE NUME	BER		29d. DAT	E SIGNED	(Month, Day, Year)
5	ora.	- 0	-40				0.4	263			P	2-	1-74
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (IT	ЕМ 27) (Туре,	Print)		0 30	,EU3					
	DR FRANCIS KHO	0.7620 YOF	RK ROA	D TOV	VSON	MD	2120	14					
	31. DATUECI 73 1994 g	alla d'aveles	SIGNATURE										

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CAN: The taw requires that the death certificate by special countries and connected with countries that the saw required by the taw required by the target of the same signed by the attending physician. Figure Date of Health and Mercal Physician and connected, of removal. Or them 23 shows any injury, or other transmitte event, the medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	29a, F/F FAES 10e. S 10e. S 11, M/I 1 1 12 17, FA 19e. H 120e. R 120e.
DALLINOTE, MARTLAND ZIZIS-UUZU OR ATTENDING PHYSICIAN: The taw mannes that the death certificate with a concentration of the physician. DIRECTOR After this certificate has been signed by the attending physician and competenty filled in by the funeral director, page 5 should be detached for use as the burial-tran focus after ceath with the State Deut of health and Media Hygione prior to barial, commission, or removal. Item 28 is marked, or litem 23 shows any injury, or other traumants event, the medical examiner must be notified at once.	COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	23. F IMMI dise- resu Sequi if an csus CAU that resu PART DI 25. WE EI 1
O THE HOSPITAL OR ATTENDING PHYSIC O THE FLYRERAL DIRECTOR After mis se is find within 72 hours after death with it MPORTANT. If Item 28 is marked,	BY COMPLETED BY PH	27. MA 2 (3 [4 [290. C

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTAL HYGIEN REG. NO	_	
	1. DECEDENT'S NAME (First, Middle, Last)	Dorsey				2. DATE OF DEATH DO DECEMBER	ŭ 94	3. TIME OF DEATH
				IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day Viser) July20,	1001 C	RTHPLACE (State or Foreign Junity) innesota
IOR	9a. FACILITY NAME (If not institution, give street Falk to Council RESIDENCE OF DECEDENT	Hospital	ER	96. CITY, TOWN O	R LOCATION OF DE	ATH	9c. COUNTY O	F DEATH
DIRECTOR	10e. STATE 10b. COUNTY	cimore	10c. CITY,	TOWN OR LOCAT	e Rive	r		16d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 101 Riverthorn	n Road		101	ZIP CODE 21220			OF WHAT COUNTRY?
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U. FORCES? 1 YES : IF YES, GIVE WAR OR DATE	2 NO	If yee, sp		IC ORIGIN? (Specify Yea n, Puerto Ricen, atc.)	6	ACE — American Indian, Hack, White, atc. pec/hy:
COMPLETED		ION 18 npleted) College (1-4 or 5+)	life. Do NOT use	rk done during mo retired.)	st of working	16b. KIND OF BUS	SINESS/INDUSTR	Y
S S	8th 17. FATHER'S NAME (First, Middle, Last)		Веат	ıtician		ME (First, Middle, Maiden	Surname)	
BE C		Foucault			Emma			
2	190. INFORMANT'S NAME (Type/Print) Charles S. Ada	ams				toute Number, City or Yow Edgewood		1040
	20e. METHOD OF DISPOSITION 1 □XBurlel 2 □ Crematton 3 □ Remove		ACE AND DATE OF	DISPOSITION (Na			CATION — City o	r Town, State
	4 Oonetion 5 Other (Specify)	IDu1	laney V	alley	Cemete:	ry12/14/9	94 Bal	to. Md.
	R. Telly	Connell		Conr	Mace A	uneral Ho	imore	Essex Md. 21221
	23. PART I. Enter the diseases, or com shock, or heart Induse.	plications that caused the tonly one cause on each	leath. Do no	t antar tha mo	da of dying, suct	ss cardiac or reapi	ratory arrest,	Approximate interval Batween
	IMMEDIATE CAUSE (Final disease or condition resulting in death) s	Respiral	DM CONSEQUENCE OF	Arres	√.			Onset and Death 46 mm
5	Sequentially list conditions, b	Emphys	ene 6 -					741
EHILLAIR	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO OR AS A CO	Scleve	lie Vo	ocula	615805 E		74
1	PART II. Other significant conditions of	ontributing to death but	not reaulting in	the undarlying	csuse given in i	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS
MEDIC	Organa Mord	dysproer	eten.	n en ti	U	1 YES 2		COMPLETION OF CAUSE OF DEATH?
S S S	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		PLACE OF GEATH		UNCERTAIN			-
2		OSPITAL: Inpatient 2 ER/Outpatie		OTHER:	5 🗆 Residence	8 Other (Specify)		
5	27. MANNER OF DEATH Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	JRY AT RK? ES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURED	
0 0	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, atr			28f. LOCATION (Street a City or Town, State)	and Number or Rui	al Route Number,
Julie		N: To the best of my knowledg						se(s) end menner as stated.
-	SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM			JEO (Month, Day, Year)
	30. HAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	(ITEM 27) (Type 5	rint)	D1086	6	12/1	2/94
1	Adam F. Szezy	210 Ski Phi		22 E J	offa Rd	Towson	md 21	1286
	DECT 3 1994	TANDIE EALLIE LITE	IRE		//			

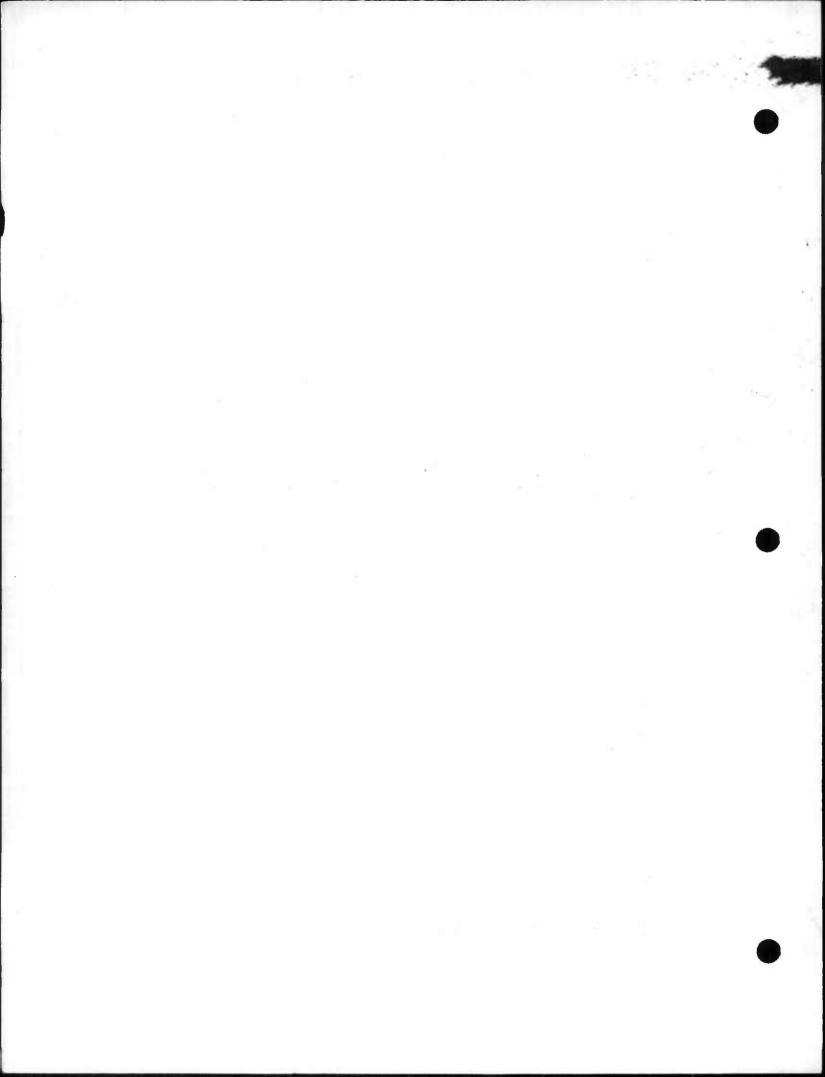
BALTIMORE, MARYLÁND 21215-0020 Eason, Horace Ray

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withh cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit permit by the present permit pe

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Lest) HORACE	RAY	EASON		2. DATE OF DEATH DAY	/ YEA	3. TIME OF DEATH A
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (UNDER t YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		RTHPLACE (State or Foreign
	238 52 3460	1 □xM 2 □ F 6	Z YRS.	HTHE DAYS HOURS MIN.	1-16-1932	Ñ	l.Carolina
DIRECTOR	9a. SACILITY NAME (If not institution, give str	+A/	96	EIKTON.	md .	Sc. COUNTY O	PE DEATH
H CH	10e. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATION			10d. INSIDE CITY LIMITS?
	Maryland Ceci	1 County		Elkton			1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 119 Maffot	Stroot	Apt#1	10f. ZIP CODE 2 1 9 2 1			OF WHAT COUNTRY?
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DECENDENT OF HISP	ANIC ORIGIN? (Specify Ver	USA	ACE — American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	Il yes, specify Cuban, Mexic	cen, Puerto Rican, etc.)	6	Black, White, etc.
D BY	3 Wildowed 4 Divorced	Yes, USA		l de la deservación dela deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación dela deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deservación de la deserv			White
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	(Give kind of work life. Do NOT use re	done during most of working	18b. KIND OF BUSII	4ESS/INDUSTR	Y .
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		School Teach	ner	Educa	tion
COM	17. FATHER'S NAME (First, Middle, Last)		8		IAME (First, Middle, Maiden St		
BE (Eason		Betty	Boyce		
2	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street and Number or Rura			
2	Mrs Janey Eas			Maffot St, A	The second second		
	1 Burlel 2 Cremetion 3 Remo		PLACE AND DATE OF D netery, cremetory or other		DATE 20c. LOCA	ATION — City o	r Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICE	Ronald W	ade,Dir	22. NAME AND ADDRESS OF	ACILITY State	Anato	my Board
CYG	/sancholler	lea	-	655W.Baltim	ore St, Ba	lto,MI	D21201
200	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that caused list only one cause on a	the death. Do not a	antar tha moda of dying, su	ch se cardiac or reapire	tory arrest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Defy dra	stein				Onset and Death
	,	DUE TO (OR AS A	CONSEQUENCE OF):	100-06-10			
NO NO	Sequentially list conditions,	CHRCINOM DUE TO (OR AS A	CONSEQUENCE OF):	ANCREAS			
CAT	if any, leading to immediate cause. Enter UNDERLYING						į
TIFI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):				
CERTIFICATION	resulting in death) LAST						
AL C	PART II. Other significant conditions	contributing to death b	ut not resulting in ti	ha undarlying cause given i			24b. WERE AUTOPSY FINDINGS
E C					PERFORM 1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME							1 YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF I		10 🗆		
SCI.	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPHAL:		26. PLACE OF DEATH (C			
HYS	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp 28e. DATE OF INJURY	26b. TIME OI	Nursing Home 5 Residence F 26c, INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW INJ	JURY OCCURE	0
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 YES 2 NO			
2 0	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	- At home, term, stree	t, lactory, offica	28f. LOCATION (Street and City or Town, State)	d Number or Ru	iral Route Number,
ETE	4 Homicide determined						
COMPLETE				t the time, date end place, and du			
CO	2 MEDICAL EXAMINER	i: On the basis of exemination	n end/or Investigation, in	n my opinion, death occured at th	ne time, date end place, end	due to the ceu	se(s) end menner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	ul r	ni	29c, LICENSE N	UMBER	29d. DATE SIG	NED (Month, Day, Year)
일	39. NAME AND ADDRESS OF PERION WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) /Type. Prir	10 44	102	- 1-10	2/22/
	William Ke	NZHIII	mD	901 Washing	tral Rid	FIN-	21921 That md
	31. DATE FILEDING M. 1301994	STARTIST OF SHE	Karlell		and the second	-//	
1 /		0					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.

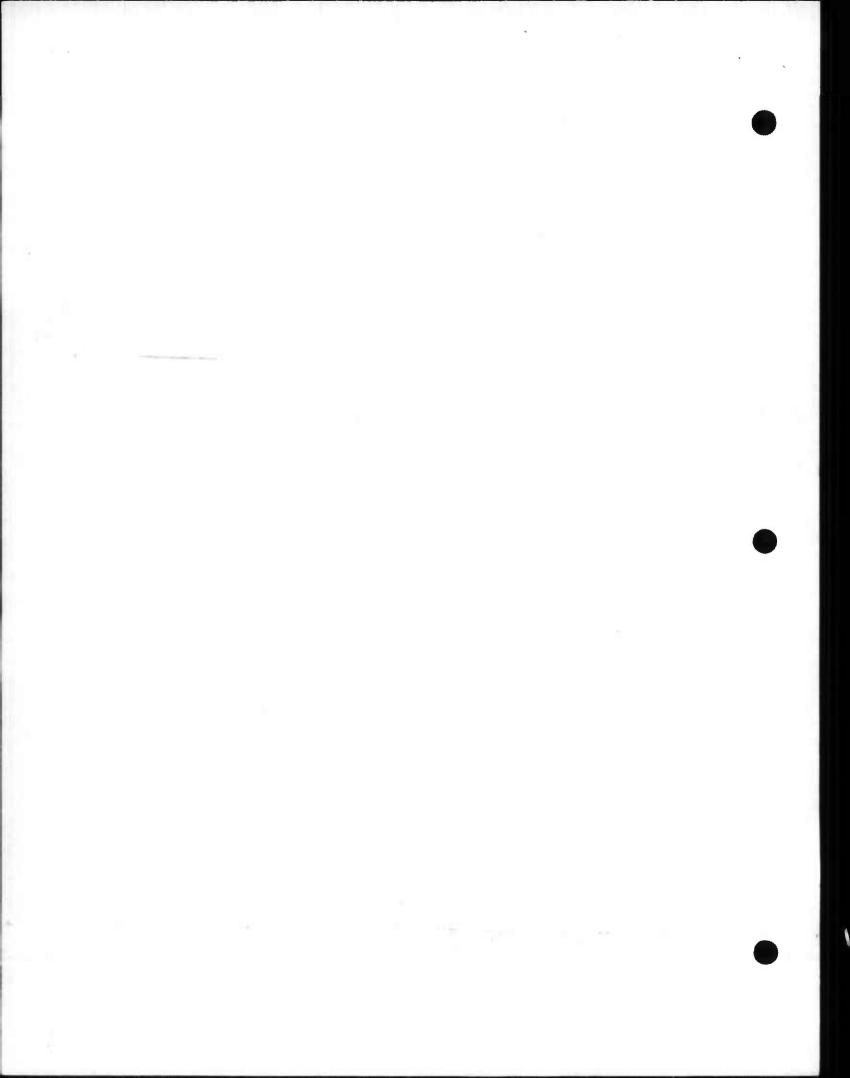
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO.			
		SINIA H	FANSLER			2. DATE OF DEATH 12-09-19	94 °	3. TIME OF DEATH 2:00 P M	
	213-22-3721	_ M 2 X F 6		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	25 W	BIRTHPLACE (State or Foreign Country) EST VIRGINIA	
DIRECTOR	99. FACILITY NAME (If not institution, give street end number) LAUREL REGIONAL HOSPITAL RESIDENCE OF DECEMENT 99. COUNTY OF DEATH PRINCE GEORGE'S								
ည္မ	40. CTATE								
	MARYLAND AND	NE ARUNDEI		SEVERN				10d. INSIDE CITY LIMITS? 1 YES 2 ANO	
FUNERAL	7965 FOSTER AV			101	21144			S.A.	
BY	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	P. Was decedent ever in (Forces? 1 Ves If yes, give war or dat	2 XNO	It yes, sp		IC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No- 14.	RACE — American Indien, Black, White, etc. Specify: WHITE	
	15. DECEDENT'S EDUCATION (Specify only highest grade com-	ION (npleted)	16a. DECEDENT'S US	NAL OCCUPATION MO	ON st of working	16b. KIND OF BUS	SINESS/INDUS	TRY	
COMPLETED		College (1-4 or 5+) N/A	ime. Do NOI use I	ET MA		CABI	NTRY	CABINETRY	
BE CON	17. FATHER'S NAME (First, Middle, Last) CHARLES EDWARD	ROCKWELL			18. MOTHER'S NAI	ME (First, Middle, Meiden E TWIC			
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AI	DDRESS (Street e	nd Number or Rural F	loute Number, City or Town	n, State, Zip Co	de)	
F	GILBERT	FANSLER	7965 E	FOSTER	AVENUE	E, SEVERN			
	20e. METHOD OF DISPOSITION 1		LACE AND DATE OF			12/14/94	CATION — CITY TOWSO	N, MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	1 6	10	1 SEC		ENUE, SINGLE MARYLA		FUNERAL HOME	
	23. PART i. Enter the diseases, or com	plications that caused	the deeth. Do not						
	ahock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death) a	Acute	ch lina.		. 1	Infar		interval Batween Onset and Daath	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A C	l I	sch	nock.			·	
EDICAL	PART II. Other significant conditions co	ontributing to death but	t not resulting in	the underlying	cause given in	Part i. 24a. WAS AN PERFOR	AUTOPSY MEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
ă	(1					1 _ YES 2	NO	OF DEATH?	
Σ	DID TOPACCO USE CO	ONITRIBUTE TO	CALISE OF	DEATH Y	ALC LES NIC			1 TYES 2 W NO	
AN	DID TOBACCO USE CO	JINTRIBUTE TO	CAUSE OF						
PHYSICIAN:	EXAMINER?	OSFITAL:		THER:	ACE OF DEATH (Che				
Ħ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME C	OF 28c. INJ	URY AT	28d. DESCRIBE HOW II	NJURY OCCUR	ED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		RK? 'ES 2 NO				
8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify	At home, farm, stre	et, tectory, office	· ·	28f. LOCATION (Street e City or Town, State)	and Number or I	Rural Route Number,	
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN 2 MEDICAL EXAMINER: O							euse(s) end menner ee stated.	
B	29b. SIGNATURE AND TITLE OF CERTIFIER	reas 1	M.D.		29c. LICENSE NUM			GNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF OEAT	TH (ITEM 27) (Type, Pr	int)	204,6	len Bun	rie.	710/99	
	31. DAT DECT 3 1994	B2. REGISTRAR'S SIGNAT	reall	1	7,3	MD	210	061	
- 100									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

or attending physician.	use as the burial-transit permit. Pages 1, 2, 3 should		
24 hours after death. Page 6 may be retained by the hospital	filled in by the funeral director, page 5 should be detached for ion, or removal.	he medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certifical be filed within 72 hours after death with the Sta	IMPORTANT: If item 28 is marked, or lit	

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTA	L HYGIEN	E		
į	1. DECEOENT'S NAME (First, Middle, Lest) LAVONNE		GEE				OF DEATH	6, 19 [§]	54	3. TIME OF DEATH 8:43P
	4. SOCIAL SECURITY NUMBER 215-70-6680 9s. FACILITY NAME (If not institution, give si	1 □ M 2 [XF 3	O YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	MAR.	of BIRTH th, Day, Year) 23, 1	958 M	ary	land
TOR		THE JOHNS HOPKINS HOSPITAL			IMORE CI			9c, COUNTY OF DEATH N/A		
DIRECTOR	10e. STATE 10b. COUNTY	N/A		TOWN OR LOCAL					- 1	10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 1119 N. Kenwood				1. ZIP CODE 21213			10g. CITIZEN	OF WI	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	CENDENT OF HISPAI ecity Cuben, Mexica 2 X NO Specifi	n, Puerto			RACE	- American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)		168	b. KIND OF BUS		TRY	
OMP	10th	N/A	LABORI	ER .	18. MOTHER'S NA	THE SECOND	FAC	-		
	Lawrence Gee				Marquer			,		
TO BE	19s. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Num	ber, City or Town	, State, Zip Co		
Ĕ	Marguerite Gee		1119 N	. Kenwo	od Avenu	ıe/Ba	ltimor	e, MD	212	.13
	20s. METHOO OF DISPOSITION 1	oval from Stats cem	netery, cremetery or oth	er place) Cemeter	У		/12 Lar			A CATACA
	21. SIGNATURE OF FUNERAL SERVICE LIC	normon		1101		Ave	nue/Ba	ltimor		MD 21202
	23. PART I. Enter the diseases, or a shock, or heart failure.	complications that caused List only one cause on a	d the death. Do no	ot anter tha mo	da of dying, suc	h as car	diac or respin	ratory arrest	,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	. LIVER	Z FAII	LURE						Onset and Death
z		DUE TO (OR AS A CONSEQUENCE OF): AL COHOLISM								
ATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF)							15 YRS 20 YRS
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST		CONSEQUENCE OF)		E				-	20 YRS
	PART II. Other aignificant condition	s contributing to death b	out not resulting in	tha underlyin	g cause givan in	Part i.	24a, WAS AN	AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS
DICAL							PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOP ACCOUNT	DIDLITE TO CALLEE O	F DE ATIL ME		1			V		1 - YES 2 NO
AN	DID TOBACCO USE CONTR		26. PLACE OF DEATH		UNCERTAIL	иП				
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER: 4 - Nursing Horr	ne 5 🗆 Residence	6 🗆 Othe	er (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		PRK?	28d. DE	SCRIBE HOW IN	JURY OCCUR	ED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be datarmined	28e. PLACE OF INJURY building, stc. (Spec	— At home, term, etcoffy)	reet, fectory, offic	•	281. LOC City	CATION (Street s or Town, State)	nd Number or	Rural Ro	oute Number,
COMPLETED		CIAN: To the best of my knowl R: On the bests of exemination							euse(s)	and manner as stated,
H	29b. SIGNATURE AND TITLE OF CERTIFIER	€ NA D			29c. LICENSE NUI	MBER		29d. DATE S	IGNED	Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO		WOLFE STR		LTIMORE	MD.	21287	- 12	-/ (6/94
	31. DECT 3 1994 Jul	A REGISTRAR RIGH						-	_	

6,

35 X MAR. 23, 1958 Maryland 215-70-6680

N/A

Baltimore A/N MD X

U.S.A. 21213 1119 N. Kenwood Avenue

X X

X Black

FACTORY N/A LABORER loth

Lawrence Gee Marguerite Rowlette

1119 N. Kenwood Avenue/Baltimore, MD 21213 Marguerite Gee

12/12 Lansdowne, MD

Mt. Zion Cemetery

March Funeral Home East

1101 E. North Avenue/Baltimore, MD 21202

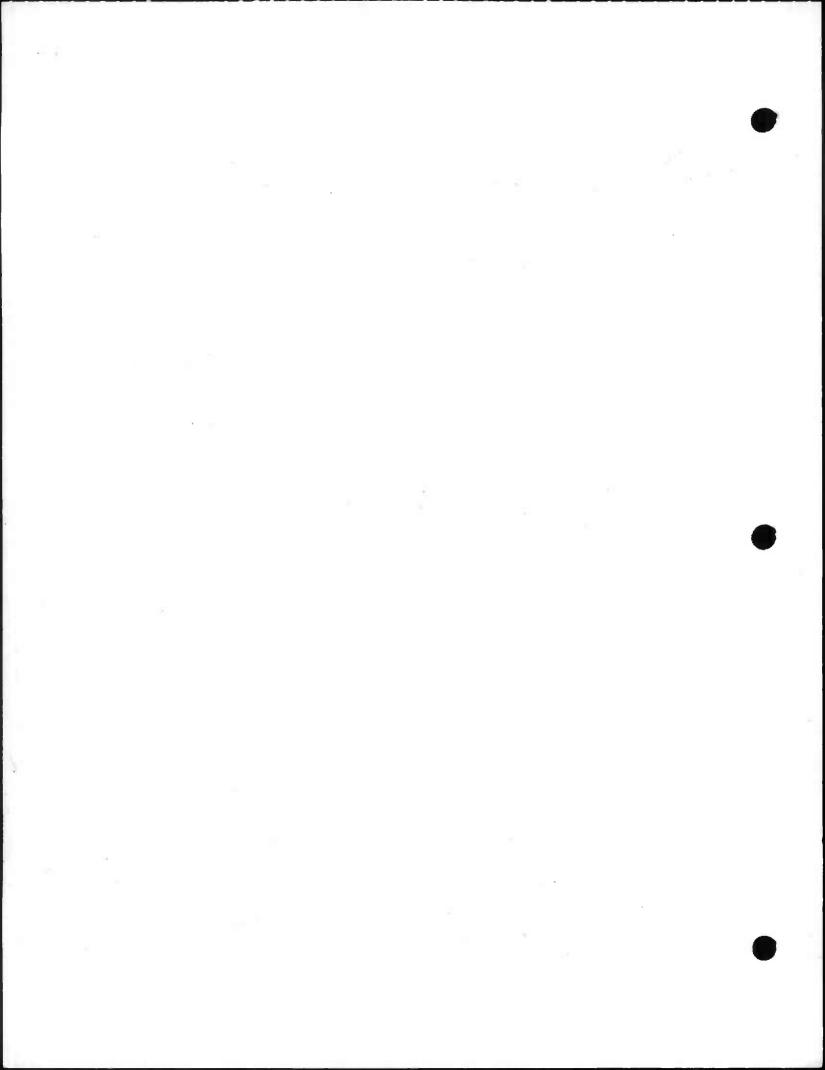
BALTIMORE, MARYLAND 21215-0020

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CE	RTIFIC	CATE OF	DEATH	RE	G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)			0			2. DATE OF DE			3. TIME OF DEATH
- 1	Margaret	GERTR	UDE	60	ines		MONTH	L DAY G	9 4	11 de P M
	4. SOCIAL SECURITY NUMBER 5.	i. SEX 6.	AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH	_	HPLACE (State or Foreign
	218-44-2776	□ M 2 KKF	56		ONTHS DAYS	HOURS MIN.	MAY22	Year)	Coun	YLAND
	9e. FACILITY NAME (If not institution, give street	7.77	30		AL OUTY TOWN	212242121121				
~						OR LOCATION OF DE		9c.	COUNTY OF	DEATH
0	l e e e e e e e e e e e e e e e e e e e	DSPITAL			BALTI	MORE CI	I Y		n/a	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			100 CITY	TOWN OR LOCAT	non-				Last maint aims
E	1775-371	. / -		IOC. CITT,						10d. INSIDE CITY LIMITS?
		n/a			BALTI					1 X YES 2 □ NO
Z.	10e. STREET AND NUMBER				101	. ZIP CODE				WHAT COUNTRY?
FUNERAL	559 NEW PI	ITTSBURG	AVENU	Ε		21222		UN	ITED	STATES
5		2. WAS DECEDENT E	VER IN U.S. ARI	MED		ENDENT OF HISPAN			- 14. RAC	E — American Indian, k, White, etc.
7	1 Never Merried 2 Married	FORCES? 1	OR DATES	10		ecify Cubsn, Mexicer 2 NO Specify		etc.)	Spec	city:
B	3 💢 Widowed 4 🗌 Divorced					XX				BLACK
	15. DECEDENT'S EDUCAT (Specify only highest grade con		16e. DE	CEDENT'S U	SUAL OCCUPATION	ON at all wardsing	16b. KIND	OF BUSINESS	S/INDUSTRY	
<u> </u>		College (1-4 or 5 +)	life.	Do NOT use	rk done during mo retired.)	st of working				
립	8 TH	-	D0	MESTI	C		HOU	JSEKEEI	PING	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			-		18. MOTHER'S NAM	ME (First, Middle.	Maiden Surnar	me)	
	PRUCE SCOTT					MARI		/ANS	,	
BE	19a, INFORMANT'S NAME (Type/Print)		101	MAILING A	DDDEER (Come)	nd Number or Rural R			71-0-11	
2	MITCHELL EVA	ANC								MD 01000
		4112					T-			MD 21222
- 1	20e. METHOD OF DISPOSITION 1 ☑ Purlel 2 ☐ Cremellon 3 ☐ Remove	I from State	20b. PLACE A cemetery, crei		DISPOSITION (Na ar place)			20c. LOCATIO	-	
ļ	4 Donetion 5 Other (Specify)		ARBU	TUŚ J	MEMORIA		12-15	ARBUTL	IS, MA	RYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICEN:	SEE	/	10	22. NAME AN	ID ADDRESS OF FAC	CILITY			
	► 100, N	21 M 00	md		WM. C	. MARCH F	H _110	1 F.	NOR TH	AVENUE
\dashv	22 2477 2-7-14	1000	170							
	23. PART i. Enter the diseases, or comehock, or heart fellure. Lie	npilicetiona that ce it only one ceuse	on each ilne	eth. Do no	t enter the mo	de of dying, auch	as cardiec o	or reapiratory	y arreat,	Approximate interval Between
- 1	IMMEDIATE CAUSE (Final									
- 1										Onset and Death
	disease or condition resulting in death)	Sepsi	5							Onset and Death
	disease or condition	Sepsi Due to (or	S AS A CONSEC	DUENCE OF):						2 days
N	disease or condition resulting in death)	Pneu	monic							2 days
TION	disease or condition	Pneu								2 days
CATION	disease or condition resulting in death) Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO COR Esupha	Menica AS A CONSEC Geal	CAUP CIN	oma					2 days
IFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO COR Esupha	MANICA MAS A CONSEC	CAUP CIN	oma					2 days
ERTIFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO COR Esupha	Menica AS A CONSEC Geal	CAUP CIN	oma					2 days
CERTIFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO COR	AS A CONSEC GEG L AS A CONSEC	CAUP CINA	oma					2 days 2 days 6 months
AL CERTIFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO COR	AS A CONSEC GEG L AS A CONSEC	CAUP CINA	oma	g cause given in l		WAS AN AUTOI PERFORMED?		2 days 2 days 6 months
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DICAL	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO COR	AS A CONSEC GEG L AS A CONSEC	CAUP CINA	oma	g cause given in I				2 days 2 days 6 months were autopsy findings MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	DUE TO (OR Contributing to december of the contributing to december of the contributing to december of the contributing to december of the contributing to december of the contributing to december of the contributing to december of the contribution of the contributi	eth but not ro SE OF DEA 28. PLAC VOutpetient 3 URY	CA, CINA CA, CINA DUENCE OF: eeulting in TH YES E OF DEATH DOA 28b. TIME INJUI	the underlying NO [(Check only one) THER: Nursing Hom OF 28c. INJ. WO M 1 1	UNCERTAIN 5 G Reeldence (URY AT RK? (ES 2 G NO	1 □	PERFORMED? YES 2 NO	0	2 days 2 days 6 months were autopsy findings MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 29 Accident Investigation 3 Suicide 6 Could not be determined 290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C	DUE TO (OR Contributing to december to CAUS BUTE TO CAUS BUTE TO CAUS CONTRIBUTION TO CAUS 280. DATE OF IN, (Month, Day, 1) 280. PLACE OF IN, building, atc. N: To the best of examination of the best of examination of the contribution of the best of examination of the contributio	eth but not re SE OF DEA 28. PLAC VOutpetlent 3 URY rear) knowledge, dei instion end/or in	DUENCE OF): CAP CINDUENCE OF): DUENCE OF): DUENCE OF): TH YES E OF DEATH DOA 10 28b. TIME INJUI me, term, str ath occurred investigation,	the underlying (Check only one) (Check only on	UNCERTAIN 5 Reeldence (URY AT RK? FES 2 NO	8 Other (Spec 26d. DESCRIBE 26f. LOCATION City or Tow to the cause(s)	end manner as	OCCURED mber or Rural s stated. lo the ceuse(2 days 2 days 6 months b. Were Autopsy Findings AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: Conditioned 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	DUE TO (OR Contributing to december to CAUS BUTE TO CAUS BUTE TO CAUS CONTRIBUTING TO CAUS 280. DATE OF IN, (Month, Day, 1) 280. PLACE OF IN, building, atc. N: To the best of my On the bests of examination of the best of examinat	eth but not re SE OF DEA 28. PLAC VOutpetlent 3 URY rear) knowledge, dei instion end/or in	DUENCE OF): CAP CINDUENCE OF): DUENCE OF): DUENCE OF): TH YES E OF DEATH DOA 10 28b. TIME INJUI me, term, str ath occurred investigation,	the underlying (Check only one) (Check only on	UNCERTAIN 5 G Residence (URY AT RK? FES 2 G NO end plece, end due t eath occurad at the t	8 Other (Spec 26d. DESCRIBE 26f. LOCATION City or Tow to the cause(s)	end manner as	OCCURED mber or Rural s stated. lo the ceuse(2 days 2 days 6 months 6 months 1 days 6 months 1 days 1 d
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTION OF CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTION OF CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTION OF CAUSE (CAUSE OF CAU	DUE TO (OR Contributing to december to CAUS BUTE TO CAUS BUTE TO CAUS CONTRIBUTION TO CAUS 280. DATE OF IN building, stc. N: To the best of my On the best of examination of the cause of the cau	AS A CONSECTION OF DEATH (ITEM DE DEATH (ITEM DE DEATH (ITEM)	DUENCE OF): CAP CINDUENCE OF): DUENCE OF): DUENCE OF): TH YES E OF DEATH DOA 10 28b. TIME INJUI me, term, str ath occurred investigation,	the underlying (Check only one) (Check only on	UNCERTAIN 5 G Residence (URY AT RK? FES 2 G NO end plece, end due t eath occurad at the t	8 Other (Spec 26d. DESCRIBE 26f. LOCATION City or Tow to the cause(s)	end manner as	OCCURED mber or Rural s stated. lo the ceuse(2 days 2 days 6 months 6 months 1 days 6 months 1 days 1 d
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: Conditioned 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	DUE TO (OR Contributing to december to CAUS BUTE TO CAUS BUTE TO CAUS CONTRIBUTION TO CAUS 280. DATE OF IN building, stc. N: To the best of my On the best of examination of the cause of the cau	AS A CONSECTION OF DEATH (ITEM DE DEATH (ITEM DE DEATH (ITEM)	DUENCE OF): CAP CINDUENCE OF): DUENCE OF): DUENCE OF): TH YES E OF DEATH DOA 10 28b. TIME INJUI me, term, str ath occurred investigation,	the underlying (Check only one) (Check only on	UNCERTAIN 5 G Residence (URY AT RK? FES 2 G NO end plece, end due t eath occurad at the t	8 Other (Spec 26d. DESCRIBE 26f. LOCATION City or Tow to the cause(s)	end manner as	OCCURED mber or Rural s stated. lo the ceuse(2 days 2 days 6 months 6 months 1 days 6 months 1 days 1 d



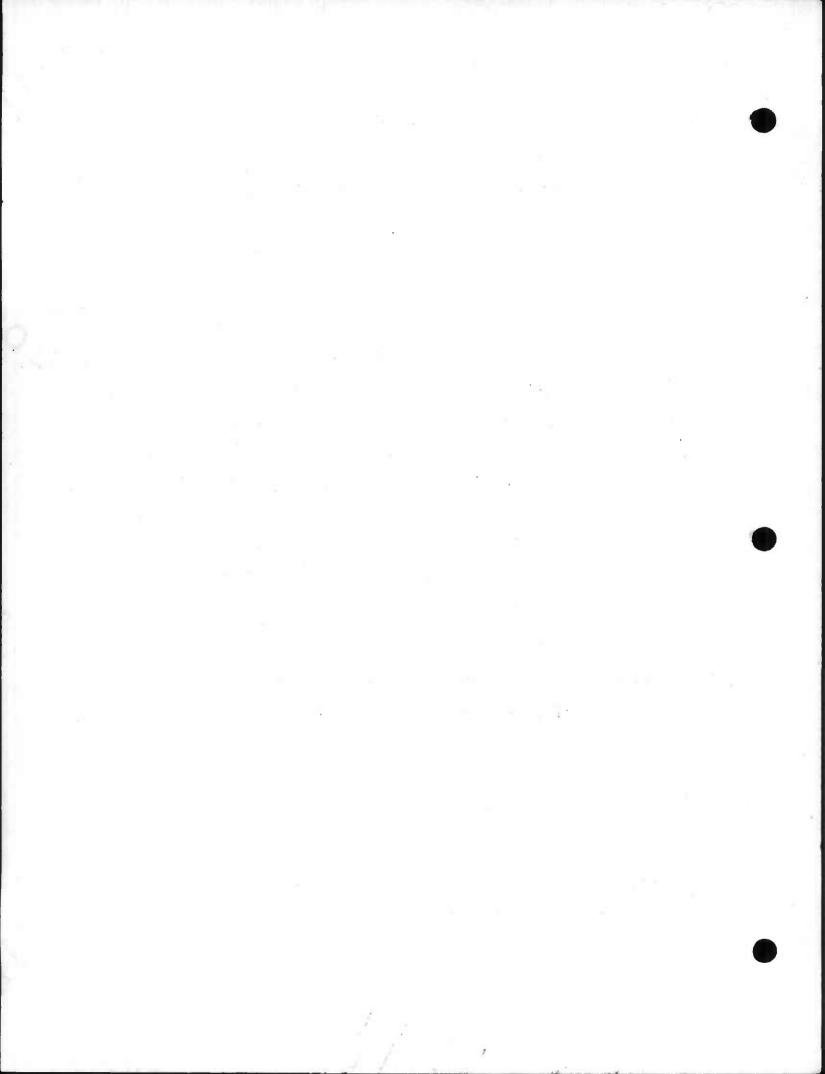
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THE HOSPITAL OF ALLENDING PRISIDIAN: THE IDM TEQUIES THAT HE DEATH CENTIFICATE DE EXECUTED WITHIN 24 THOUS ALLE DEATH. PAGE & MAY DE TELLINE OF THE) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be dig	i filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or n	APORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at office.
3	N.	WITH	AN
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•	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.										
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CERTIFI	CATE OF	DEATH	REG. NO		3. TIME OF DEATH			
1	William.	E. Edward	60	eorg	e sr.	MONTH D	1 90				
		SEX 8. AGE (In yrs.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12–13–192:	8. B	OUNTRY AND			
	9e. FACILITY NAME (If not institution, give street	<u> </u>		9b. CITY, TOWN C	N OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
0 B O	ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE A										
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	, TOWN OR LOCAT				10d, INSIDE CITY LIMITS?			
	MARYLAND QUE	EN ANNE			NSVILLE			1 TYES 2 THO			
ERA	100. STREET AND NUMBER 100. STREET AND NUMBER										
FUN	11. MARITAL STATUS 12 1 Never Married 2 Married	. WAS DECEDENT EVER IN U.S. FORCES? 1 XYES 2		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yes	or No- 14, 1	RACE — American Indien, Black, White, atc.			
By	3 Widowed 4 Divorced	1943-1945			2 NO Specif			Specify: WHITE			
LETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	npleted)	DECEDENT'S U (Give kind of wo life, Do NOT use	ISUAL OCCUPATIO	ON all of working	16b. KIND OF BUS	SINESS/INDUSTI	RY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)			SALESM	AN RETA	IL SAI	LE			
Comp	17. FATHER'S NAME (First, Middle, Last) EDJAN RHODES	GEORGE Edgan			18. MOTHER'S NA	ME (First, Middle, Malden		DIGE			
BE	19a. INFORMANT'S NAME (Type/Print)				MARY	MARGAF Route Number, City or Tow		RICE			
2	SHARON ELAINE O	SEORGE						MD. 21666			
	20a_METHOD OF DISPOSITION 1	trom State 20b. PLAC	E AND DATE OF	F DISPOSITION (Na.	me of 12 CEMETER	/15°/94 20c. LO	CATION — City				
	21. SIGNATURE OF FUNERAL SERVICE LICENS		VEIL	22. NAME AN	ID ADDRESS OF FA	CILITY S	ingleton	LLE, MD.			
	Michael C	Jaklen.	0)	l SE	COND A	VENUE, S. E, MD. 21	W.				
	23. PART I. Enter the diseases, or com shock, or heart failure. List	plications that crused that only one cause on each li	daath. Do no	ot anter the mod	da of dylng, suc	h as cardiac or reapi	retory arrest,	Approximata Interval Batween			
	IMMEDIATE CAUSE (Final disease or condition	Brain St	RUL	info	eict			Onset and Daath			
	DUE TO (OR AS A CONSEQUENCE OF):										
NO.	Sequantially list conditions, b.	Attero =	EQUENCE OF								
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	Hypoten	scoi	Soll	suig a	acute	and				
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (SIR AS A CONS	EQUENCE OF)		emo	\					
2	PART II. Other significant conditions c				Cause given in	Part I. 24a. WAS AN	AUTOBEV	24b, WERE AUTOPSY FINDINGS			
CA	renal failu	V Q		the diluzitying	, cause given in	PERFOR	IMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE			
ME					,			OF DEATH? 1 YES 2 NO			
PHYSICIAN: MEDICA	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL			(Check only one)	UNCERTAIL	1 🗆 📗					
YSIC	1 YES 2 NO	OSPITAL: Xinpetient 2 ER/Outpetient		OTHER: 4 - Nursing Home	e 5 🗆 Residence	8 Other (Specify)					
1 1	27. MANNER OF DEATH 1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	RK?	28d. DESCRIBE HOW I	NJURY OCCURE	D			
2 Accident Investigation 3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, term, street, tactory, office building, etc. (Specify) 28. LOCATION (Street and Number or Ru City or Town, State)								ural Route Number,			
COMPL		N: To the best of my knowledge, on the basis of examination and/o						iss(s) and manner so stated			
BE CC	29h, SIMNATURE AND TITLE OF CERTIFIER	0.5			29c. LICENSE NUI			NED (Month, Day, Year)			
10 B	40cell Nolls	eleco i	WD		DZO	731	▶ 12	-12-94			
		AUD. ST.	223	AI	una p	olls =	2140	/			
	DECT 3 1994	32. BEGINTRAPIO SIGNATURE	Phylose								

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

0020	g physician.	e burial-transit permit. Pages 1, 2, 3 should	
BALTIMORE, MARYLAND 21215-0020	. Page 6 may be retained by the hospital or attendi	ral director, page 5 should be detached for use as	iner must be notified at once.
DF VITAL RECORDS, P.O. BOX 68760,	NG PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thit the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	TANT: if Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RE	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requir	TO THE EMERAL DIRECTOR: After this certificate has been significant with the State Dept. of H.	IMPORTANT: If Item 28 is marked, or Item 23 show

	FOR 1 STATE	STATE OF MARY				MENTAL HYGIEN	E	, 0		
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	BDIICE HV	CERTIFIC		DEATH	REG. NO. 2. DATE OF DEATH MONTH DA	NY.	YEAR 3. 1	TIME OF DEATH	
		BRUCE HARRY GRUBER					, 1994	1	3:56 P M	
	219-20-2913	∑ M 2 □ F		NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan. 3, 19	CE (State or Foreign			
OR	se. FACILITY NAME (If not institution, give stree Harbor Hospital	91		imore	EATH	9c. COUNTY OF DEATH				
ם	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	DR. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.								
- DIRECTOR	Maryland NA		1 '	imore	(Wagner	s Point)	12	LIMITS?		
FUNERAL	3821 Fourth Av	enue,		1	21226	5	10g. CITIZE	USA	COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 [X] Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR I WW 2	IN U.S. ARMED 2 NO DATES Navy	If yes, s	CENDENT OF HISPAN pecify Cuban, Mexical S 2 X NO Specify		or No- 1	I4. RACE — I Black, W? Specify:	American Indian, lite, atc. White	
9	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION	16a. DECEDENT'S US	UAL OCCUPAT	ION post of working	16b. KIND OF BUS	INESS/INDU	STRY	MITTEE	
COMPLETED		College (1-4 or 5+)	Home Im	etired.)		Self-e	employ	/ed		
Ď	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NAI	ME (First, Middle, Maiden				
BE (Samuel G	ruber			Anne	Shu	ірр			
2	19e. INFORMANT'S NAME (Type/Print)	•				Route Number, City or Town				
_	Mrs. Betty Nancy					ltimore, M				
	20a, METHOD OF DISPOSITION Burlel 2 Cremation 3 Ramova Donation 5 Other (Specify)	I from Stata ce	metery, cremetory or other Cedar Hill	Cemet	ery 12/	14/94 Balt	cation — ci	e, Mar	sum Yland	
Surial 2 Cremation 3 Removal from State Cegnetary, crematory or other place) Cedar Hill Cemetery 12/14/94 Baltimore, Maryla Cemetery 12/14/94 Baltimore, Maryla Cemetery 12/14/94 Baltimore, Maryla Cemetery Cemetery 12/14/94 Baltimore, Maryla Cemetery										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):									
DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL C	CARDNIC OBSTRUCTUZ DUMONAM DISEASE PERFORMED? 1 YES 2X NO OF D							RE AUTOPSY FINDINGS ILABLE PRIOR TO INPLETION OF CAUSE DEATH? YES 2 NO		
z	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE OF I	DEATH	YES NO					
당	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL -			PLACE OF DEATH (Che	eck only one)				
1 Vestural 2 Accident Investigation										
								JRED		
COMPLET		to the cause(a) and man			d manner as stated.					
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER								SIGNED (Mo	nth, Day, Year)	
Dr. Francine Higgs-Shipman, M.D. 3001 S. Hanover St., Balto., Md. 21225									225	



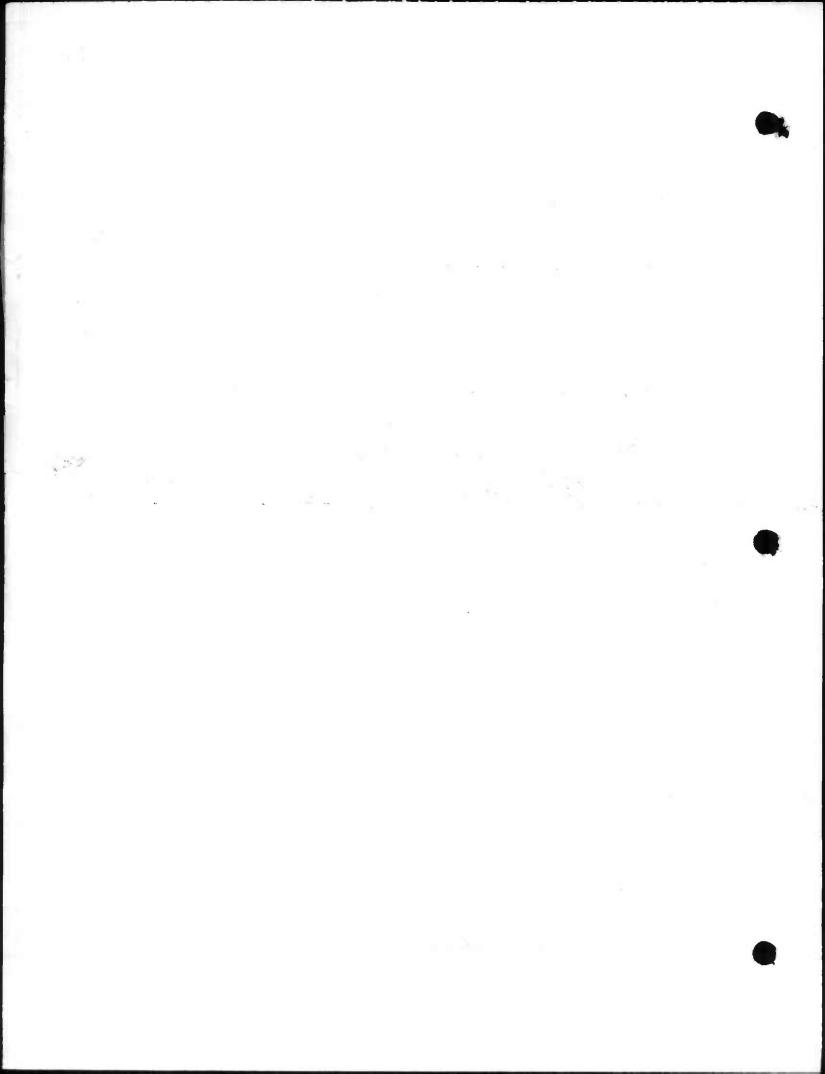
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGI				
	1. DECEDENT'S NAME (First, Middle, Last)	hilbert			2. DATE OF DEAT	DAY	VEAD	TIME OF OEATH		
	4. SOCIAL SECURITY NUMBER 579-18-1309	5. SEX 8. AGE (In		IF UNDER 24 HRS. HOURS MIN.	S. 7. DATE OF BIRTH (Morith, Dey. Year) 2 / 1 / 2 MD					
OB	99. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SINAIT HOSPITAL BALTIMORE									
DIRECTOR	10e. STATE 10b. COUNTY	ION	10d. INSIDE CITY							
	MD 10. STREET AND NUMBER	ZIP CODE		10g. CITIZI		X YES 2 □ NO AT COUNTRY?				
FUNERAL	6614 CROSS CC		21215		US					
B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexica 2 NO Specif	- American Indian, White, etc. BLACK						
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementery/Secondary (0-12)		16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during mo etired.)		16b. KIND OF	BUSINESS/INDU	STRY		
NO N	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Me				
BE	GILBERT SEWARD- 190. INFORMANT'S NAME (Type/Print)	HINES BANF		DDESC (Street o		PARRIS				
2	SONDRA BANFIELI		6614	CROSS	COUNTE	RY BLVD.	BALT			
	20e. METHOD OF DISPOSITION 1	ceme ME	PLACE AND DATE OF E Bry, crematory or other TRO CRE	MATOR	me of Y 12-12	2-94 C2	LOCATION — CI			
	21. SIGNATURE OF FUNERAL SERVICE LICE			ALB		WYLIE H				
	23. PART I. Entar the diseases, Dr c	opplications that caused	tha death. Do not	antar the mp	da Df dying, suc	MOR ST.	eapiratory arres	st,	Approximata Interval Between	
	iMMEDIATE CAUSE (Final disease or condition resulting in daath)	DUE TO (OR AS A C							Onset and Death 3 days	
ATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE DF):							
₽.	PART II. Other significant conditions as piration	a contributing to death but	not reaulting in t	ha underlying	j cause given in	PER	S AN AUTOPSY FORMED?	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	DEATH YES	□ NO I	UNCERTAIL	_		1	YES 2 NO	
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		THER:						
HYS	1 VES 2 NO 27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O	F 28c. INJ	JRY AT	6 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCU	RED		
BY F	1 Natural 5 Pending 2 Accident Investigation	28e. PLACE OF INJURY	INJUR	M 1 1	ES 2 NO					
E	3 Suicide 6 Could not be determined		261. LOCATION (Street and Number or Rural Floute Number, City or Town, State)							
COMPLETED		CIAN: To the best of my knowled: On the besis of examination							nd menner ee stated.	
296. DATE SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED Month Day, Year)									fonthy Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Pri		2402321-	AH9827) /.	4/11	194	
	DEC1 3 1994	32. REGISTRAR'S SIGNAT	URE							

DHMH-16 Rev 1/89



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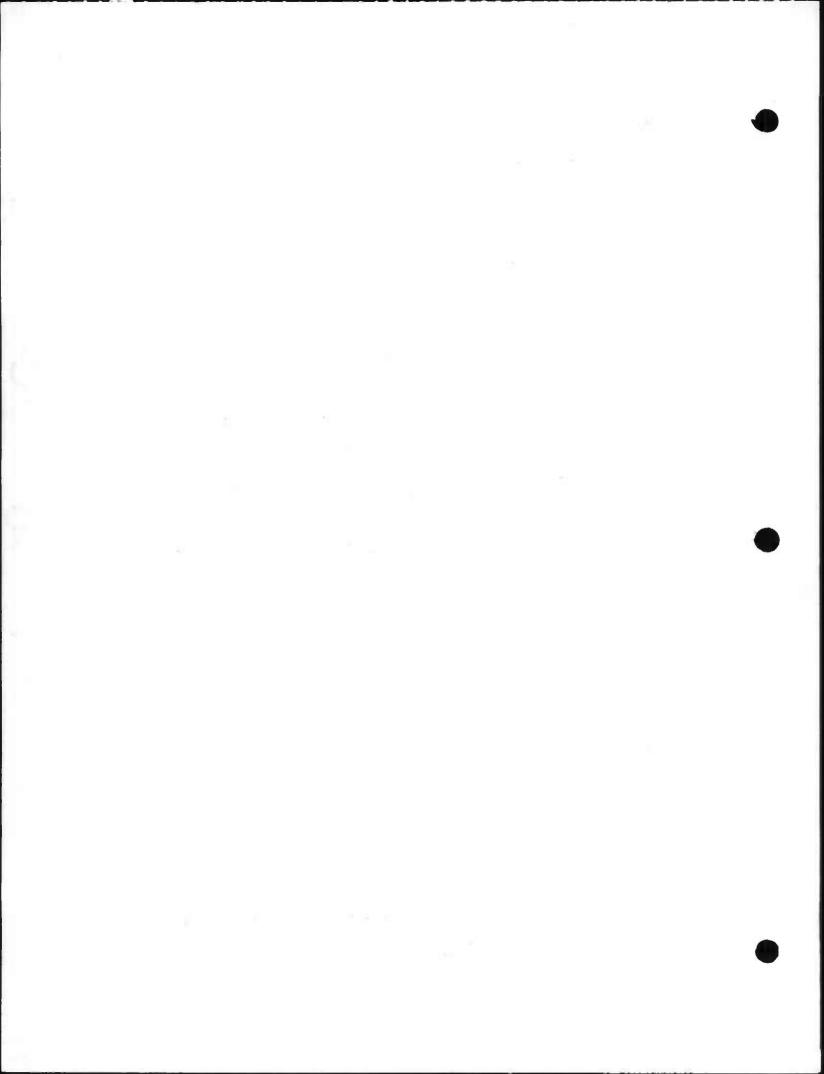
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last)			OLIVIII	IOAT		DEA			G. NO.		
		NATHANIEL				GARVINS & DEC.					TE OF DEATH 3. TIME OF DEAT 7:38		
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs.	fact blotheless	IF UNDER		T .	-				
	1	21-=32-5020	1 5 M 2 F	70	YRS.	MONTHS	DAYS	IF UNDER	MIN.	7. DATE OF BII (Month, Day,	Year)	8. BIRT	
should		9a. FACILITY NAME (If not institution, give		70		Oh CITY	(TIOWAN	OR LOCATIO	ON OF DE	02-18	_		SC
85 (S)	Œ			งากเรา		1.00			ON OF DE	AIH	- 1	9c. COUNTY OF I	DEATH
1. 2,	o LIBERTI MEDICAL CENTER BALTIMORE												
ages	I III I	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN (OR LOCA	ATION					10d. INSIDE CITY LIMITS?
jë.												1- YES 2 NO	
per											WHAT COUNTRY?		
ransit	<u>5126 SEKOTS ROAD 21207 US</u>									USA			
nysicii urial-t	교	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S.	ARMED	13.	WAS DE	CENDENT O	F HISPAN	IC ORIGIN? (Spen, Puerto Rican,	ecify Yea or	No- 14. RAC Blac	E — American Indian, k, White, atc.
2 4	⋒	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	•			S 2 7 NO				Spec	Hy: BLACK
as as	<u>a</u>	15. DECEDENT'S EDU	ICATION	16a.	DECEDENT'S	USUAL O	CCUPATI	ION		16b. KIND	OF BUSIN	ESS/INDUSTRY	
_ 3		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 -	-	(Give kind of a life. Do NOT us	work done is se retired.)	during m	ost of workin	g				
thed 1	茰	10th			R	IGGI	ΕR						
detach once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	HER'S NA	ME (First, Middle,	Maiden Su	rname)	
od be	BE (NATHANIEL	GARVIN					R	ILL	ER GAR	VIN		
5 should be detached for notified at once.	2	19a. INFORMANT'S NAME (Type/Print)								loute Number, Cit			
age 5	-	NATHANIEL GAR	VIN JR.		1819	N.	CO	LLIN	GTO	V AVE.	BAI	LTO. M	D. 21213
. ta		20s. METHOD OF DISPOSITION 1 M Burial 2 Cremation 3 Ren	oval from State	20b. PLAC	CEAND DATE	OF DISPOS	SITION (N	lame of				TION — City or To	
directic		4 Donation 5 Other (Specify)	revers -	MT.	ZIO						LANS	SDOWNE	MD.
tuneral di i. examiner		21. IMANATURE OF PUNETIAL SERVICE D	CEMBER		_			ND ADDRES			21	1017	
en -: en	. 10	638 N. GILMOR ST. 21217 ALBERT P. WYLLE F/H PA											
d in by the or removal.		23. PART I. Enter the diseases, or copperications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									Approximate		
											Intarval Between Onset and Death		
		disesse or condition resulting in death)	a. HHE	roscle	rothe	Ca	rel	ROV.	RAU	elar	here	lan	
S 5 - 6			DUE TO	(OR AS A CON	SEQUENCE OF	F):							2
at pag	NO	Sequentially list conditions,	b. DUE TO	(OR AS A CON	SECUENCE OF	ъ.							
the attending physician a Mental Hygiene prior to ijury, or other traum.	RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	002 10	(On AS A COM	SECUENCE OF	-):							
attending physician mtal Hygiene prior to y, or other traun	[윤]	CAUSE (Disease or Injury that initiated events	cDUE TO	(OR AS A CON	SEOUENCE OF	F):							
Hygi Or of	H	resulting in death) LAST	d										
the atte Mental njury,	CE	DADT II. Other clanificant condition											
y ly	CAL	PART II. Other algnificant condition	a contributing to	daath but no	ot resulting	in the un	ndariyin	ng causa g	ivan in		MAS AN AU		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
signed Health a	EDIC									_ 1 -	YES 2	MO	COMPLETION OF CAUSE DF DEATH?
	Σ	DID TODA CCO LICE COAT					=						1 TES 2 NO
cate has been State Dept. of Item 23 sho	AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIROJE JO CA		LACE OF DEAT				ERTAIN				
State Item	SICIAN:	EXAMINER? 1 TYES 2 NO	HOSPITAL:	1000		OTHER	₹:						
certif	PHY	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF	_	JURY AT	sidenca	28d. DESCRIBE		JRY OCCURED	
fter this cath with marked		1 Natural 5 Pending	(Month, Di	ay, Year)	INI	URY	W	ORK? YES 2	NO			00001120	
Afte deat	D BY	2 Pulate	28a. PLACE O	F INJURY — At	home, farm, s	street, fact	ory, offic	ca		281. LOCATION	(Street and	Number or Rural	Route Number,
4 Homicide determined City or Town, State)								n, State)					
								r as stated					
크 이 ==	(Original Property of the Control of								s) and manner as stated.				
TO THE FUNERAL be filed within 72 I	- 11	29b. SIGNATURE AND TITLE OF CERTIFIE						29c. LICE					
Filed APOR	B	Dans -/	What.						.C.N		ľ	DEC . 08	0 (Month, Day, Year) B , 1994
2 6 8 ₹	욘	30. NAME AND ADDRESS OF PERSON AND	O COMPLETED CAUS	SE OF DEATH (I	ТЕМ 27) (Туре,	Print)							
		U		1.1	1 Pe	nn ^c	stra	eet.	Bai	ltimor	e. N	(arvla	nd 21201
-		31. DATE FILED (Month, Day, Year)		R'S SIGNATURE			, , ,			LETHOT	J 1	LULY LU	21201
		DFC1 3 1994 Jul	in Dewalton	Rardall									
			112										DHMH-18 Ray 1/89



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use as the burial-transit permit. Pages 1, 2, 3 should DIRECTOR 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Washington Clear Spring FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 12305 Funkhouser Road 21722 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Married 1 YES 2 X NO Specify: BY 3 Widowed 4 Divorced WWII COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only his į Elementary/Secondary (0-12) College (1-4 or 5+) 9 should be detached Storekeeper 17. FATHER'S NAME (First, Middle, Last) Millard Filmore Gladhill Ħ BE notified 19a. INFORMANT'S NAME (Type/Print) 0 page 5 s Dolores M. Gladhill after death. Page 6 may be pe 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Parkhead Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 12/10/94 the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY filled in by the fon, or removal. 23. PART I. Enter the diseases, or complications that caused the data shock, or heart failure. List pnly one cause on each line. cremation, or IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSE completely other traumatic event, executed with Mental Hygiene prior to burial. en and CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING physician 8 death certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avanta attending reauiting in death) LAST 0 Injury. signed by the a Health and Meni PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. the MEDICAL requires that shows any blooding Health ; peen ō PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TO Dept. MB 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item State **EXAMINER?** certificate OTHER 1 YES 2 NO PHYSICIAN: 1 | Inpetient 2 | ER/Outpetient 3 | DOA the 28a. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? marked, with this 1 Natural 2 Accident 1 YES 2 NO B Investigation After death ATTENDING 28e. PLACE OF INJURY — At home, farm, street, tactory, offica building, etc. (Specify) 3 Sulcide .00 ETED 8 Could not be 28 CHRECTOR 4 Homicide TOO! them COMPLE HOSPITAL DR a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my kno TO THE HOSPITAL OF THE FLANERAL DE BIND WITHIN 72 P. CHATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 씵 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 150 31. DATE EILED (Month, Day, Year)
DECT 3 1994 32 REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MillARD GlAdt Vec 4. SOCIAL SECURITY NUMBER 5 SEY 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 6. BIRTHPLACE (State or Foreign 216-22-8509 1X M 2 | F 67 28,1927 April Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington County Hospital Hagerstown Washington 10d. INSIDE CITY 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? **USA** 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rican, etc.) White 16b. KIND OF BUSINESS/INDUSTRY Chessie System 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Margaret Mills 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12305 Funkhouser Rd. Clear Spring, MD. 21722 20c. LOCATION — City or Town, Stata Big Pool, MD. 21711 Grove Funeral Home P.O.Box 368 141 West Main St. Hancock, MD. 21750 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate interval Between Onset and Death Hrs 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED viedge, danth occurred at the time, data and place, and due to the cause(a) and manner as stated. and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year,

 BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, I	
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	ENE
		CI	ERTIFICATE	OI	E DEAT	ГН		REG.	NO.

1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTI			MENTAL HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, Last)					2. OATE OF DEATH	v = 7	3. TIME OF DEATH
ANTHONY M. GO	VER				DECEMBER 1	1. 1994	11.33 A M
4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (II		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Dev. Year)		THPLACE (State or Foreign
CI4 72-4444	M 2 □ F	29 YRS.	ONTHS DAYS	HOURS MIN.	September 18		
9a. FACILITY NAME (If not institution, give street		9	b. CITY, TOWN	OR LOCATION OF O		9c. COUNTY OF	
THE JOHNS HOPKINS	HOSPITAL			ORE CITY		BALTIM	ORE CITY
10a. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
Maryland Balti 100. STREET AND NUMBER	more City		10	Baltim r. ZIP CODE	10g. CITIZEN OF	1 XYES 2 □ NO WHAT COUNTRY?	
828 Park Avenue	Apartment 3	BF		21201		II.	S.A.
II	. WAS OECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	CENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No- 14. BAI	CE — American Indian, ick, White, atc.
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		3 2 X NO Specific	n, Puerto Rican, etc.)		-14
15. DECEDENT'S EDUCATI			1				White
(Specify only highest grade com-	pleted)	(Give kind of work life. Do NOT use n	k done during mo	ON ost of working	16b. KIND OF BUS	INESS/INOUSTRY	
Elementary/Secondary (0-12)	ollege (1-4 or 5+)			terrol and	Doots	- + / 0	
17. FATHER'S NAME (First, Middle, Last)	1.5	261.0	er / S	tudent	ME (First, Middle, Maiden	ant / St	tudent
Russell David	Cover Sr					•	
19a. INFORMANT'S NAME (Type/Print)	GOVEL, SI.		DRESS (Street)		thy McKeo Route Number, City or Town		
Mr. Stephen Hartm	an	1			3F Baltim		21201
20a, METHOD OF DISPOSITION	20h	PLACE AND DATE OF I				CATION — City or	
1 Donation 5 Other (Specify)		etery, crematory or other roll Cremat	ion Serv	rices 1	2/14/94 Ha	mostead	MD
21. SIGNATURE OF FUNERAL SERVICE LICENS		/	7	NO ADDRESS OF FA		poodaa	110
Rugar	L.XI	15	HAI	GHT FUNE	RAL HOME	(P.O. Box	(195)
23. PART I. Enter the diseases, or com	plicetions that caused	Ma death Do not	enter the mo	Kesville	, MD 21784	(410)-	795-1400 Approximata
ahock, or heart fallura. List	only one cause on a	ich Ilna.	orner tha me	or dying, ade	ir aa cerdrac or respir	atory arreat,	Intarval Between
IMMEDIATE CAUSE (Final disease or condition resulting in death)	KAPO!		ARC	OMA			Onset and Death
	DUE TO (OR AS A	CONSEQUENCE OF):	1000	1.1.100	V-C1/15W	CN	1640005
Sequentielly list conditions, b	OUE TO JOB AS A	CONSEQUENCE OF:	IM	MUNUI	EFILIEN	JUT	10 1011
If any, leeding to immediate cause. Enter UNDERLYING	00E 10 (0N A3 A	consedence or).					
CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					-
resulting in deeth) LAST							
BART II Other slowlilleans and district							
PART II. Other algnificant conditions of	ontributing to death bu	it not reaulting in t	the underlyin				
III				g cause given in	Pert I. 24a. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
				g cause given in	Pert I. 24a. WAS AN PERFOR	MED?	
					PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
DID TOBACCO USE CONTRIB			□ NO □		PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPJTAL:	26. PLACE OF DEATH (□ NO □		PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEATH (atlent 3 DOA 4	Check only one) THER:	UNCERTA!	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPJTAL:	26. PLACE OF DEATH (Check only one) THER: Nursing Horn F 28c. INJ	UNCERTAIN	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH Netural 5 Pending Investigation	OSPITAL: OSP	28. PLACE OF DEATH (stient 3 DOA 4 28b. TIME O INJURY	NO Check only one) THER: Nursing Hore Nursing Hore Y	UNCERTAIN THE 5 Residence SURRY AT SHK? YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW IN	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH Notural 5 Pending	OSPITAL: OSPITAL: OSPITAL: Openiant 2 - ER/Output 28e. DATE OF INJURY	28. PLACE OF DEATH (outlent 3 DOA 4 28b. TIME 0 INJUR At home, farm, stree	NO Check only one) THER: Nursing Hore Nursing Hore Y	UNCERTAIN THE 5 Residence SURRY AT SHK? YES 2 NO	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 1 27. MANNER OF DEATH Thetural 5 Pending Investigation 3 Suicide 8 Could not be determined	OSPITAL: Input and 2 = ER/Output 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, atc. (Speci	28. PLACE OF DEATH (stient 3 DOA 4 28b. TIME 0 INJUR At home, ferm, stre-	Check only one) THER: Nursing Horn F Y M 1 et, factory, office	UNCERTA!!	6 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	MED? NO IJURY OCCUREO and Number or Rural	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 1 27. MANNER OF DEATH 1 Sturrel 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER 12 CERTIFYING PHYSICIAN (Check only	OSPITAL: Inputant 2 = ER/Output 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, atc. (Speci	28. PLACE OF DEATH (stient 3 DOA 4 28b. TIME 0 INJUR At home, ferm, stre- (y)	Check only one) THER: Nursing Hom WY M 1 et, factory, office	UNCERTA!!	6 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	MED? NO IJURY OCCUREO and Number or Rural mer as stated.	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO	OSPITAL: Inputant 2 = ER/Output 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, atc. (Speci	28. PLACE OF DEATH (stient 3 DOA 4 28b. TIME 0 INJUR At home, ferm, stre- (y)	Check only one) THER: Nursing Hom WY M 1 et, factory, office	UNCERTAIN THE S Residence SURTY AT SPREY TYPES 2 NO THE STREET NO THE STREE	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a City or Town, State) to the cause(a) and man	MED? NO NO NUMBER OF RURS NO RURS	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 1 27. MANNER OF DEATH 1 Sturrel 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER 12 CERTIFYING PHYSICIAN (Check only	OSPITAL: Inputant 2 = ER/Output 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, atc. (Speci	28. PLACE OF DEATH (stient 3 DOA 4 28b. TIME 0 INJUR At home, ferm, stre- (y)	Check only one) THER: Nursing Hom WY M 1 et, factory, office	UNCERTA!!	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a City or Town, State) to the cause(a) and man	MED? NO NO NUMBER OF RURS NO RURS	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 11 27. MANNER OF DEATH 1 Hetural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. PLACE OF INJURY building, stc. (Speci	28. PLACE OF DEATH (atlent 3 DOA 4 28b. TIME 0 INJUR At home, farm, stre- fy) adge, death occurred a and/or investigation, i	Check only one) THER: Nursing Hom Fr WC M 1 ct, factory, office at the time, data in my opinion, o	UNCERTAIN THE S Residence SURTY AT SPREY TYPES 2 NO THE STREET NO THE STREE	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a City or Town, State) to the cause(a) and man	MED? NO NO NUMBER OF RURS NO RURS	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO	28e. PLACE OF INJURY building, stc. (Speci	28. PLACE OF DEATH (attent 3 DOA 4 28b. TIME 0 INJUR At homa, farm, stre- fly) At homa, farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly) At homa farm, stre- fly)	Check only one) THER: Nursing Hom Fr WC M 1 ct, factory, office at the time, data in my opinion, o	UNCERTAIN THE S Residence SURTY AT SPREY TYPES 2 NO THE STREET NO THE STREE	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a City or Town, State) to the cause(a) and man	MED? NO NO NUMBER OF RURS NO RURS	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			ERIIF	CALE	UF	DEAL	Н		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Leist) LEANNER	1		111	ICHEC				MONT		AY 1.0	YEAR	3. TIME OF DEATH
		5. SEX 8.	AGE (In yrs.		IF UNDER 1	VEAD	IF UNDER	0. (ma	DECEMBER 8, 1994				5:11 p. м
		1 🔀 M 2 🗆 F	37						SEPT 26 57 S. BIRTHPLACE (State or Foreign Country)				
	9e. FACILITY NAME (If not institution, give stre		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							EATH			
DIRECTOR	THE JOHNS HOPK		BALTIMORE CITY										
106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. BN T. TO LIN									10d. INSIDE CITY				
								LIMITS?					
FUNERAL	3305 FERNDALE									ZEN OF WHAT COUNTRY?			
ᄬᅵ		AVE	VER IN U.S.	ARMED	13 W								E — American Indian,
XIX Never Merried 2 Merried Married Security Cuben, Mexicen, Pue Security Cuben, Pue Security Cuben, Pue Security Cuben, Pue Security Cuben, Pue Security Cuben, Pue Security Cuben, Pue Security Cube								n, Puerto		07 NO-	Black	White, etc.	
입	t5. DECEDENT'S EDUCA (Specify only highest grade of		16a.	DECEDENT'S	USUAL OC	CUPATIO	N		160	. KIND OF BU	SINESS/INI	DUSTRY	
	Elementary/Secondery (0-12)	College (1-4 or 5+)	1	(Give kind of w life. Do NOT us	e retired.)	unng mo	st of working	g					
COMPLETED	1 OTH 17. FATHER'S NAME (First, Middle, List)			LABO	RER	_				-			
BE CC	WILBERT HUGHE	S					ET			Middle, Maiden IPSON	Surname)		
P 0	19e. INFORMANT'S NAME (Type/Print)			195. MAILING	ADDRESS	(Street a	nd Number	or Rural R	Poute Num	ber, City or Tow	n, State, Zij	D Code)	
٦	ETTA B. HUGHES			330	5 F	ERN	DALI	E AV	/E E	BALTO	MD	212	207
20e. METHOD OF DISPOSITION XXBuriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN								Y	121	20c. LO	CATION —	•	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
	> Blad	a WÖ	ano				-			4300			AVE
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Purport (OR AS & CONSCOUENCE OF):											Interval Between	
RTIFICATION	Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury			EOUENCE OF		æ							years
CERTIF	that initiated eventa resulting in death) LAST	DUE TO (OF	R AS A CONS	EOUENCE OF	n: 								
- 11	PART II. Other algnificent conditions	contributing to de	eth but no	t resulting I	n the und	derlying	cause g	iven in f	Pert I.	24a. WAS AN	AUTOPSY	24b.	. WERE AUTOPSY FINDINGS
EDICAL	Renal Failure	, Sips	i)				11000.3			PERFOR	~ 1		AVAILABLE PRIOR TO COMPLETION DF CAUSE
MEC		4								1 123			OF DEATH? 1 ☐ YES 200000
ž	DID TOBACCO USE CONTRI	BUTE TO CAUS	SE OF DE	ATH YE	S 🗆 N	10 🗆	UNC	ERTAIN	10				
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DEAT	H (Check or								
Z	1 YES 2000	16 Inputient 2 - El		3 DOA	4 Nursi		5 🗆 Res	sidence (8 🗆 Othe	r (Specify)			
2	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28e. DATE OF INJ (Month, Day,		28b. TIME INJI	OF 2 URY M	28c. INJI WO 1 Y	URY AT RK? 'ES 2 [NO	28d. DE	CRIBE HOW I	NJURY OC	CURED	
ED B	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF Inbuilding, etc.	IJURY — At I (Specify)	home, ferm, s	treet, fector	ry, office	,		28f. LOC City	ATION (Street a or Town, State)	and Number	or Rural R	Route Number,
9	29e. CERTIFIER											_	
COMPLET	(Check only												eowysta III santa
3	2 MEDICAL EXAMINER:	7	ettori attu/0	- arvestigetioi	-, пт тлу ор	miron, de				ena piace, en			
O BE	296. SIGNATURE AND TITLE OF CHIPFIER	Kul 1					29c. LICE	4(n	57		29d. DAT	SIGNED	(Month, Day, Year)
=	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	SA (IT	EM 27) (Type	/1	0.0	,1	10	7	1705			
	31. DATE FILED (MONTH DONN'S)	2 RECISTRAF	SIG A VRE	179	Mo	1	U			1003			
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

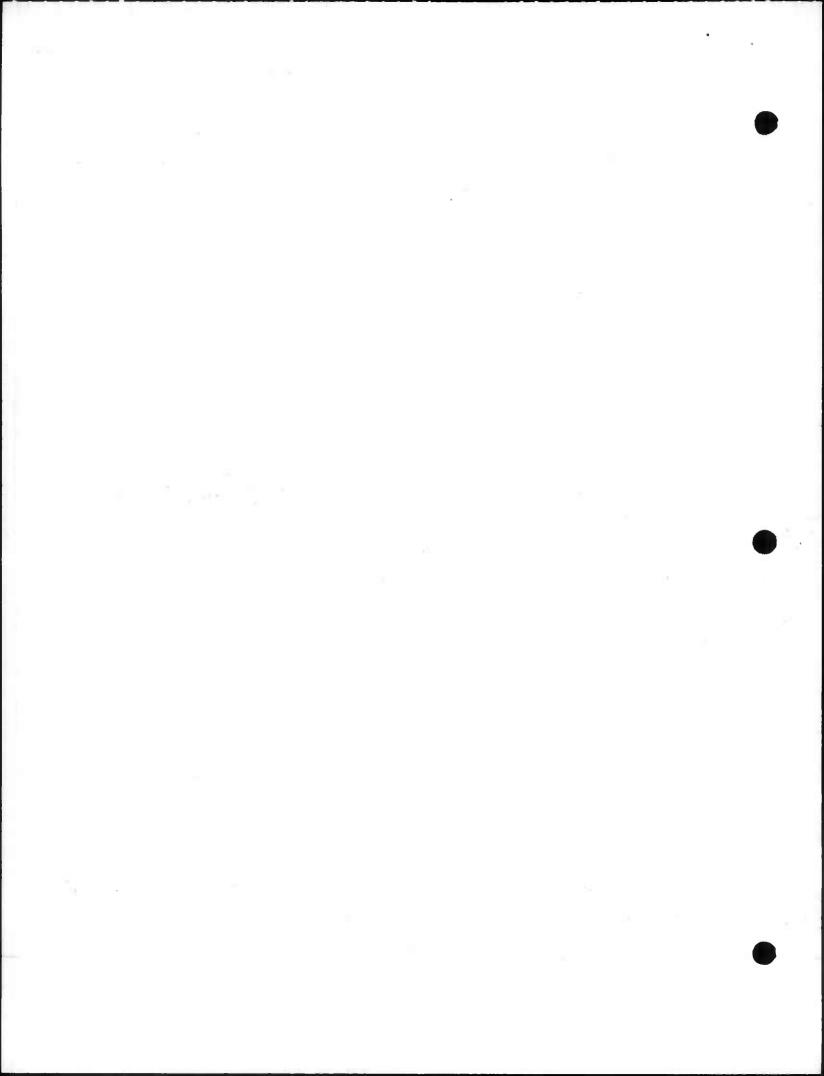
ITEMS: 1. & 7. PER F.H. FILM G-718 12/13/94 t.t.

	1 - STATE STATE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last) OSBORNE EBERHARD' HEDGES, SR. 2. DATE OF DEATH MONTH 12 1 DAY 1 9 YEAR 3. TIME OF DEATH 12 1 DAY 1 9 YEAR											
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M M 2 F 4. AGE (In yrs. last birthdey) 1 VRS. 5. SEX 1 M M ONTHS 1 M											
DIRECTOR	DEA: ton Speciality Hospital whome Balto - Becounty of Death RESIDENCE OF DECEMENT											
HESIDENCE OF DECEDEND 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION												
1. 1.00												
FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 115 STEVENS ROAD 21060 U.S.A.											
ВУ	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 15. WES 2 NO IF YES, GIVE WINTON DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.) 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.) 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.) 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)											
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	٦										
COMPLETED	TRUCK MECHANIC AUTO GARAGE											
BE CO	17. FATHER'S NAME (First, Middle, Last) JAMES WILLIAM HEDGES 16. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL MCCREADY											
10	19a. INFORMANT'S NAME (TyperPrint) ROBERT G. HEDGES 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 STEVENS ROAD, GLEN BURNIE, MD. 21061											
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece) MD. VETERANS CEMETERY 20c. LOCATION — City or Town, State CROWNSVILLE, MD.	1										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOM 1 SECOND AVENUE, S.W.	Ð										
	M. Done e Hacking GLEN BURNIE, MD 21061	╛										
	23. PART i. Enter the diseases, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between											
	IMMEDIATE CAUSE (Final disease or condition resulting in death) 6. Due to (or as a consequence of): Onset and Death Onset and Death											
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
FICAT	CAUSE (Disease or injury											
CERTIFICATION	that initisted events resulting in death) LAST d											
ICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	1										
MEDIC	1 YES 2 NO COMPLETION OF CAUSE OF DEATH?	J										
Σ.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) FXAMINER?	7										
YSI	1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Very 1 Very 2 No.											
2 Accident												
	a nomiciae detarmined	_										
COMPLETED	299. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, end due to the cause(a) and manner se etated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and piece, end due to the cause(a) and manner se stated.	Ì										
B	296. SIGNATURE AND TITLE OF CERTIFIER ROOM MD 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 15253 12.10-94	1										
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GOVINDA BAO RAYADORG MD.	1										
	31. DATE FILED (MONIA Day 1997) DEC 13 1994	+										

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the mount after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	Item#1 Per F.	.H. Fil	m# G-7	18 1	2/1	3/9	4 R.	M.	PACALTAL	UVCIEN	e e			
	1 - STATE REGISTRAR	SIMIL OF I	C	ERTIF	ICAT	E OF	DEA	TH	MENIA	REG. NO.	<u> </u>			
	1. OECEDENT'S NAME (First, Middle, Lest) CHRISTINE	-M MARY							MONTI	OF DEATH DA	10,	1994	3. TIME OF DEATH 10:50 AM M	
	4. SOCIAL SECURITY NUMBER 218-01-0232	218-01-0232 1 M 2 1/2 F 75 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Ver) 09-13-19										8. BIRTHPLACE (State or Foreign Country) MARYLAND		
OR	90. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE 9c. COUNTY OF DEATH A.A. COUNTY													
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				Y, TOWN								10d. INSIDE CITY LIMITS?	
	MARYLAND 100. STREET AND NUMBER	ANNE AI	RUNDEL		- LTI		CUM	E			10a CIT	IZEN OF 1	1 YES 2 NO	
FUNERAL	6224 WOODLAND					2	1090					U.S.		
B≼	11. MARITAL STATUS 1 Never Married 2 Married 3 N Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2X	RMED NO		If yes, sp	ecify Cubs	OF HISPAN In, Mexice Specify	n, Puerto I	i? (Specify Yea Rican, atc.)	or No-	14. RACI Blac Spec	E — American Indian, k, White, alc. #y: WHITE	
TED	15. DECEDENT'S EDUC (Specify only highest grade Elamentery/Secondary (0-12)	completed)	(1)	ECEDENT'S Give kind of e. Do NOT u	work done	during mo	ON st of workli	ng	16b.	. KINO OF BUS	INESS/ING	DUSTRY		
COMPLETED	12 17. FATHER'S NAME (First, Middle, Last)	NONE	,)	HOME	-						НОІ	ME		
BE CC	ATWOOD	T	ATE					DEL:	LA	Widdle, Maiden			EONARD	
2	MR. EDMUND V.	HARNST	ROM, 7	645 (NOOE	s (Street a)STR	EAM	or Rural F	Y, I	oer, City or Town	, State, Zip	D •	20723	
20e, METHOO OF DISPOSITION 1 IX Burlel 2 Cremetton 3 Removal from State 4 Oonation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK ELKRIDGE, MI														
	21. SIGNATURE OF FUNERAL SERVICE LICE	The	Li		22.	NAME AND SE	CONI	SS OF FAC DAV	VENU	INGLE E, S ARYLA	TON	FUN	NERAL HOME	
	23. PART I. Enter the disease, or c shock, or heart failura. L IMMEDIATE CAUSE (Final disease or condition	omplications that	t caused the dise on sach lin	eath. Do i	not enter	the mo	de of dy	ing, such	h se card	liac or raspi	ratory ari	rest,	Approximata interval Between Onset and Death	
_	resulting in death) S. DUE TO (OR AS A CONSEQUENCE OF): G. J. J. J. J. J. J. J. J. J. J. J. J. J.													
ATIO	Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	P):	~	+	9 ./ v	N &)	/			Jen	
_	PART II. Other algnificant conditions	contributing to						given in	Part I.	24s. WAS AN PERFOR	MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
PHYSICIAN: MEDICA									_	1 - YES 2,	NO		OMPLETION OF CAUSE DF DEATH?	
IAN	DID TOBACCO USE CONTR	IBUTE TO CA		CE OF OEA			UNC	ERTAIN	1 🗆	_				
YSIC	1 TES 2 NO	HOSPITAL:		-			• 5 □ Re	aldenca	6 🗆 Other	r (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Printer S Pending Investigation	28s. OATE OF (Month, D		26b. TIM	E OF JURY M		URY AT RK? 'ES 2	NO	28d. DES	CRIBE HOW IN	JURY OC	CURED		
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE O building,	F INJURY — At he etc. (Specify)	ome, farm,	street, fact	tory, affic			28f. LOCA City	ATION (Street a or Town, State)	nd Number	or Rural I	Route Number,	
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER												i) and manner as stated.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	00 0	1 6				29c. LICI	ENSE NUM	IBER		29d. DAT	E SIGNEO	(Month, Day, Year)	
ဥ	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF OEATH (ITE	M 27) (Type	, Print)		01	88	2	3	P /	2/10	1/94	
	CONSTANTINE PADUS	SIS. M.D	/500 EN			ERS/	7310	RIT	CHIE	HGWY.	/GLE	N BU	RNIE,MD	
	DEC1 3 1994	In dia	r's signature Class Road	fall									21061	



REG. NO.

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BALLIMORE, MARYLAND 21215-00	executed within a nours after death. Page 6 may be retained by the hospital or attending p	
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1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS P.O. BOX 687

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	1 8	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR 1. 1994 8.20 7														
	1	Sceniber 10, 1994										8:20 A.	_			
		MONTHS DAYS HOURS MIN. (Mor							(Month, Da	(Month, Day, Year) Country)						
should		212-26-1780 9e. FACILITY NAME (# not ins	ethution ribm e		95	1113.	Ob OIT	700000	2010017		July 8	, 18			Maryland	_
3 %	Œ.	96. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH Dulaney Towson Nursing Home Towson Baltimo:														
5.	стов	RESIDENCE OF DEC	EDENT	ISING NO.	ille				TOWS	OH				ват	cimore	_
Pages	DIRE	Maryland	10b. COUNTY	, altimore		10c. Cl	TY, TOWN (TIDN WSON						10d. INSIDE CITY LIMITS?	
permit		10e. STREET AND NUMBER						10	f. ZIP COD	E			10g. CITI	ZEN OF V	WHAT COUNTRY?	_
- ES	ER	1412 E. Jopp	a Roa	d						2128	6			US	A	
Z I D-UUZU attending physician. ise as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 1 3 🔀 Widowed 4 Divor		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	2X ND If yes, specify Cuben, Mexice				n, Mexice	en, Puerto Ricen, atc.) Bis					
as th	ED B		DENT'S EDU	CATIDAN	40	- DECEDENT		2011217							White	_
or atte	ETE	(Specify only	highest grade	completed)		(Give kind of life. Do NOT L	work done	SUAL OCCUPATION At done during most of working retired.				INESS/IND	USTRY			
g g C	P	Elementary/Secondary (0-	12)	College (1-4 or 5	+)	Schoo		ache	r			Edi	ucati	ion		
he hospit detached	COMPL	17. FATHER'S NAME (First, Mid	ddle, Last)							HER'S NAI	ME (First, Middl		_			-
क्र वि	ш	George Buckl	.ey							Emma	a Hors	eman	,			
retained 5 should	TO B	19e. INFORMANT'S NAME (Ty	pe/Print)			19b. MAILIN	G ADDRESS	S (Street	and Number	r or Rural R	Route Number, C	ity or Town	. Stete, Zip	Code)		_
2 2 2	F	Mrs. Patrici	a M.	Evans		25 Te	nbur	y Ro	ad	Luth	ervill	e, M	aryla	and :	21093	
may be		20e, METHOD OF DISPOSITION 1 Sp Burlel 2 Cremation		oval from State	20b. PL	ACE AND DATE	OF DISPOS	SITION (N	ame of		DATE	20c. LO	ATION —	City or To	wn, State	
eath. Page 6 ma funeral director,	. 4	1 to Burlet 2 Cremation 3 Ramoval from State Cemetery, organitors, organitations, organitors, organitors, organitors, organitors, organito									13/94	Ba.	ltimo	ore l	Maryland	
th. Pa		21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE	2		22.	NAME A	ND ADDRE	SS OF FAC	CILITY					
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ted within hours after completely filled in by the fall, cremation, or removal event, the medical		ehock, or heart fellure. Liet only one ceuse on each line.										Approximata Interval Betwee Onset and Deat				
be execucian and or to bur	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE. (Places or lain).														
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puires that the signed by the Health and DWS any In	EDICAL	CHF	, 0	steoar	hunt's,	40	101	27-	o.SC	54	10	PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
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The law required the law required to State Dept. of the 23 sh	IAN	25. WAS CASE REFERRED TO		(IDOIL TO CA		PLACE DF DEA	_			EKIAII	ושי					
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PHYSICU TE CETT THE THE NEED, OR	PHY	27. MANNER DF DEATH 1 Natural 5 P	ending	26e. OATE DF (Month, D	INJURY	26b. TIA		28c. INJ WC	URY AT DRK?		26d. DESCRIE		JURY OCC	CURED		_
TENON E	ETED BY	3 Suicide 6 C	could not be etarmined	28e. PLACE O building,	PF INJURY — atc. (Specify)	At home, farm,	street, fect	ory, offic			26t. LOCATIDE City or To	N (Street ar	nd Number	or Rural R	oute Number,	
HOSPITAL OF FUNERAL DIFE WITHIN 72 HOUR TANTE IN HER	COMPLE			CIAN: To the best of R: On the beels of e) end menner ee stated.	
FUNE MITHIN	EC	29b. SIGNATURE AND TITLE								ENSE NUM					(Month, Day, Year)	_
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FFA	5	30. NAME AND ADDRESS DE	-					. 10	1 00-	1200 =	Mass	lana	21.00	24	(- (
5		Kenneth Gree 31. OATE FILED (Month, Day, M		34 REGISTRA	York		Sult(= T(T TO	wson	, Mary	Land	212(J4		_
		DEC1 3 195	14 Ja	ho dimento	Change	Ч										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

SAME AND A SOCIAL SECTION OF THE SEC

F VII AE RECORDS, P.O. BOX 68760. BALIIMORE, MARYLAND 21215-0020	Suchar. The law requires that the control of the complete whilm and completely filled in the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be called for use as the bunial-transit permit. Pages 1, 2, 3 should	medical examiner must be notified at once.
TO THE MACHINE DAYS CIVIL The law requires that the death configure to secured within	TO THE FUNCTION THE CATEGORY. THE CATEGORY OF A CATEGORY O	

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICALE	OF DEATH		REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						ATE OF DEATH	iv.	3. TIME OF DEATH
1		Leo Hoec	K]	Dec. 11	. 19	94 9:15 am
			(In yrs. last birthda			HRS. 7. D	ATE OF BIRTH Month, Day, Year)		B. BIRTHPLACE (State or Foreign Country)
		XM 2 □ F 7) YRS	MONTHS	DAYS HOURS I	Mu Au	g. 09,1	924	Maryland
	9e. FACILITY NAME (If not institution, give street	t end number)		9b. CITY, 1	OWN OR LOCATION	OF DEATH		9c. COUN	TY OF DEATH
OR	3646 Day Road			Dan	clington	า		На	rford
5	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY								
DIRECTOR			10c. t	ATY, TOWN OR					tod. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	asco		ваус	net Po	ınt			1 TES 2 X NO
FUNERAL		ala Tarra			101. ZIP CODE		7	t0g. CITIZ	EN OF WHAT COUNTRY?
Ä	12501 Stagecoad	CI Lane				3466			USA
	1 Never Married 2 XMerried	FORCES? 1 YES	2 NO	If y	S DECENDENT OF P	fexican, Pue		or No-	14. RACE — American Indian, Black, White, atc.
₽	3 Widowed 4 Divorced	WW TT	ATES	10	YES 2 XNO	Specify:			Specify: White
	15. DECEDENT'S EDUCAT	TION	tee. DECEDENT				16b. KIND OF BUS	I SINESS/INDL	
E	(Specify only highest grade con Elementary/Secondery (0-12)	mpleted) College (1-4 or 5 +)	(Give kind tife. Do NO!	of work done du use retired.)	ing most of working				
립	11th	somege (I-V or S Y)	Mana	rer			Grocer	v St	ore
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER	'S NAME (F	irst, Middle, Maiden		OIC
BE C	John Joseph	n Hoeck			Mar	e Ce	ecelia	Schn	Oenia
	t9e. INFORMANT'S NAME (Type/Print)		t9b. MAILI	NG ADDRESS (Street and Number or				
임	Betty Lee Hoeck		12501	Stage	coach La	ne B	Bavonet I	oint	, FL 34667
	20e. METHOD OF DISPOSITION t □ Buriel 2 X Cremetion 3 □ Remove	201	PLACE AND DAT	E OF DISPOSIT	ON (Name of		DATE 200 LO	CATION C	the as Town State
	4 Donetion 5 Other (Specify)	Me	etro Cre	ematory	, Inc.	12/12	:/94 B	alti	more, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE Dawn F. 1	McDonald	22. N/	ME AND ADDRESS	OF FACILITY	1		
	- warmam	de mala		20	emation	Socie	ty of Ma	ıryıaı	nd, Inc.
	23. PART I. Enter the diseases, or com	polications that cause	d the death. Do	not enter th	9 FLEGEL	ICK R	d. Balti	unore.	MD 21228
	shock, or heart failure. Lie	t only one ceusa on e	ach line.		o mode or cynny		out and of 100pt	ratory arre	interval Between
	IMMEDIATE CAUSE (Finel disease or condition	M	0, 0	rac.	- 11			-	Onset and Death
ł	resulting in death)	Malignant DUETO (OR AS	CONSEQUENCE	OF:	us wealt	-	n respirat	cry Col	mpromus 2 months
-		Metaotat				4		/	11 1/
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS			21011011	~			11 month
8	cause. Enter UNDERLYING CAUSE (Disease or injury								
E	that initieted events	DUE TO (OR AS	CONSEQUENCE	OF):					
CERTIFICATION	resulting in deeth) LAST								
	PART II. Other significant conditions c	ontributing to deeth b	eut not recultin	In the unde	erlying ceuse give	n in Part	I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
EDICAL							PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	.0						t 🗌 YES 2	NO NO	DF DEATH?
Σ	DID TOBACCO USE CONTRIB	SLITE TO CALISE C	E DEATH	/ES 🏻 N/	O UNCER	TAINI F	,		t TYES 2 NO
₹ I	25. WAS CASE REFERRED TO MEDICAL	OUT TO CAUSE C	28. PLACE OF DE			IAIN L	1		
PHYSICIAN:	EXAMINER?	OSPITAL:		OTHER:	g Home 5 K Resid		Other (Conside)		
Ħ	27. MANNER OF DEATH	26e. DATE OF INJURY	28b. T	ME OF 2	Sc. INJURY AT		DESCRIBE HOW II	NJURY OCCI	JRED
	1 Netural 5 Pending	(Month, Day, Year)	_ '	NJURY M	WORK?	0			
BY	2 Accident Investigation 3 Suicide 8 Could not be	280. PLACE OF INJURY	- At home, fern	, atreet, fector	, office	28f.	LOCATION (Street a	and Number o	r Rural Route Number,
ĬĮ.	4 Homicide determined	building, etc. (Spec	eny)			1	City or Town, State)		
mi I	29e, CERTIFIER	N; To the best of my know	ledge, death occu	rred at the time	date and place an	d due to the	rause(e) and men	mer en elete	
7 1	CERTIFYING PHYSICIAL								
MPL	(Check only T CERTIFYING PHYSICIAL		n end/or investiga						
COMPLETED	(Check only		n end/or Investiga			ENIMBED		204 DATE	
H H	(Check only one) 2 MEDICAL EXAMINER: C		n end/or Investiga		29c. LICENS		3	29d. DATE	SIGNED (Month, Day, Year)
- 11	(Check only one) 2 MEDICAL EXAMINER: C	On the beele of examination					3	29d. DATE	SIGNED (Month, Day, Year)
8	(Check only 1 CERTIFYING PHYSICIAL ON 1 CERTIFYING PHYSICIAL ON 1 CERTIFYING PHYSICIAL CAMINER: C	On the beele of examination		oe, Print)	MO O		3	29d. DATE	SIGNED (Month, Day, Year)
8	(Check only 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: CO 296. SIGNATURE AND TITLE OF CERTIFIED AND ADDRESS OF PERSON WHO CO ADDRESS OF PERSO	On the beele of examination		oe, Print)	29c. LICENS		3 lue (-	20d. DATE ► 12	SIGNED (Month, Day, Year)
8	(Check only one) 2 MEDICAL EXAMINER: CO	M D MD MD MPLETED CAUSE OF DE		oe, Print)	MO O		3 lue (-	20d. DATE 12	SIGNED (Month, Day, Year)

BALTIMORE, MARYLAND 2121	irs after death. Page 6 may be retained by the hospital or atte	n by the funeral director, page 5 should be detached for use a
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atte	DIFFER HIS CERTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a

/	1 - FOR STATE REGISTRAR		STATE OF I	MARYLANI) / DEPAI	RTMENT	OF I	HEALTH	AND	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (FA	st, Middle, Last)	пур	VESON					<u>-</u>	2. DAT	E OF DEATH	NA .	YEAR	3. TIME OF DEATN
	KABIII	والمائل	IIAK	V ESON						DE			994	1:30 Am
	4. SOCIAL SECURITY NUI 219-58-283		5. SEX 1 3 M 2 F	8. AGE (In yrs		MONTHS	YEAR DAYA	HOURS	R 24 HRS.	7. DATE (Mon	of BIRTH th, Day, Year) 1e 24,]	.950	a. BIRTN Country New	PLACE (State or Foreign) Jersey
	9e. FACILITY NAME (If not	institution, give s	treet and number)			9b. CITY,	TOWN	OR LOCATI	ION OF D				NTY OF D	EATH
DIRECTOR	68 mirio	m ct.				OW	INC	GS M	ILL	S		B.	ALTI	MORE
EC	10e. STATE	10b. COUNTY			10c. Cl	TY, TOWN OF	R LOCA	TION						10d. INSIDE CITY
	Md.		timore			Owing	_	Mills						1 YES 2 NO
FUNERAL	68	Miriam	Court				10	211					.S.A	/HAT COUNTRY?
BY FUR	11. MARITAL STATUS 1 Never Merried 2 [3 Widowed 4 Di			IT EVER IN U.S YES 2 WAR OR DATES	ARMED	It	yee, sp		en, Mexica	in, Puerto	N? (Specify Yee Rican, etc.)	or No-		- American Indien, , White, etc.
		CEDENT'S EDU		16e	DECEDENT'S	USUAL OC	CUPATI	ON		16	b. KIND OF BUS	SINESS/IND	USTRY	
IPLET	Elementary/Secondary	nly highest grade (0-12)	College (1-4 or 5	+)	Mana		uring mo	ost of worki	ng		Gro	cery	Stor	e
COMPL	17. FATNER'S NAME (First,		rlton Har	veson				18. MOT	NER'S NA	ME (First,	Middle, Meiden y Yocu	Surneme)		
TO BE	19e, INFORMANT'S NAME	(Type/Print)	2004 1101		19b. MAILIN	ADDRESS	(Street	and Number	or Rural	Route Nun	Califo	n, State, Zip	Code)	-
	Carol Ge			20b BLA	CEANDDATE	_			ni Ba	DA		CATION —		
	1 Donation 5 Oth	tion 3 🗆 Reme er (Specify)		cemetery	Metro	cher piece) Crem	ato	ry :	Dec.	12,	1994	Balti	more	e, Md.
	21. SIGNATURE OF EURE	SERVICE LIC	lland	4		Ec	kha	rdt .	Fune	ral	Chapel	Owin	es h	21117 Mills, Md.
	23. PART i. Enter the shock, pr iMMEDIATE CAUSE (f disease or condition resulting in death)	haart fallure.	a. The	t caused the	line.	not enter t	he mo	ode of dy	ing, suc	h sa cai	diac or reapi	retory arr	est,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list cond if sny, leading to imm cause. Enter UNDERL CAUSE (Disesse or in that initiated events resulting in death) LA	ediata YING jury	b DUE TO	(OR AS A CON	ISEOUENCE C	PF):								
ا بـ	PART II. Other signific	cant condition	s contributing to	desth but n	ot resulting	in the und	lerlyin	g cause (given in	Part I.	24a. WAS AN	*****	24b.	WERE AUTOPSY FINDINGS
MEDIC						<u> </u>				_	1 YES 2			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO	USE CONTR	RIBUTE TO CA	USE OF D	EATH Y	ES 🗆 N	0 [JUNC	ERTAII	N 🗆				7
SICIAN:	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:	26. P	LACE OF DEA									
ַהַ	1 VES 2 NO		1 Inpatient 2	ER/Outpatien	3 🗆 DOA	OTHER:		ne 5 🗆 Re	eeldence	6 🗆 Oth	er (Specify)			
PH	27. MANNER OF DEATH 1 Netural 5	Pending	26e. DATE OF (Month, D	lay, year)	26b. TII	IE OF	WC	JURY AT DRK?	V	26d. DE	SCRIBE NOW II	NJURY OCC	URED	Λ
5	2 Accident	Investigation	1411	1 1	00001		1 🔲		NO	Subj	ect Su	reking	inte	S.
2	3 Suicide 6 A Nomicide	Could not be determined	building,	of INJURY — A: otc. (Specify)	l home, term, Welli	1	ry, offic	•		261. LOI City	CATION (Street a or Town, State)	and Number	11	Biltery ore Con
3	29e. CERTIFIER	RTIFYING PHYSI	CIAN: To the best of	my knowledge		7	ne, date	end place	, end due			ner se stat		Meryland
*														end menner ee stated.
3	29b. SIGNATURE AND TITI								ENSE NUI					11122
200	- Theodore	4.	Thongs e	e. D.					C.M					(Month, Day, Year) 11,1994
- 1	30. NAME AND ADDRESS	OF PERSON WHO	O COMPLETED CAU	SE OF DEATN (ITEM 27) (Type	e, Print)								

32. REGISTRAR'S SIGNATURE

111 Penn Street, Baltimore, Maryland 21201

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART			MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) Sally C. Herb	erson				2. DATE MONT	E OF DEATH		EAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 217-18-3828	1 □ M 2√2/F	E (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR WONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mon	th, Day, Year)	6,	Country)	NCE (State or Foreign
TOR	98. FACILITY NAME (If not institution, give si Meridian RESIDENCE OF DECEDENT	reet end number)			imore	EATH		9c. COUNTY	OF DEAT	н
DIRECTOR	Md. 10a. STATE 10b. COUNTY			town or Loc						d. INSIDE CITY LIMITS? YES 2 \(\text{NO} \)
FUNERAL	100. STREET AND NUMBER 5616 A McCLear			1	01. ZIP CODE 2/234			10g. CITIZEN	S. A.	T COUNTRY?
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 — YES IF YES, GIVE WAR OR	S 2 NO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexico S 2 NO Specif	en, Puerto	N? (Specify Yes Rican, etc.)	or No— 14.	RACE — Black, W Specify:	American Indian, Thite, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		life. Do NOT use	ork done during n retired.)	ION post of working	16	b. KIND OF BUS		(RY	whete
	17. FATHER'S NAME (First, Middle, Last)		House	wife	16. MOTHER'S NA					
TO BE	George O. Dize 190. INFORMANT'S NAME (Type/Print) Beverly A. Unk				Ruth end Number or Rural	Route Nun	aber, City or Town			
	20e. METHOD OF DISPOSITION 1 1 Suriel 2 Cremetion 3 Remo	21	Db. PLACE AND DATE OF or oth	er piace)	Clare !		Balta TE 20c. LO			State State
	21. SIGNATURE OF FUNERAL SERVICE LIC	And H		22 NAME	tley Mi. Harfo	CHITY				2/234
	23. PART I Enter the diseases, or c shock, or heart fellure.	omplications that ceue	ed the deeth. Do no each line.	t enter the m	ode of dying, euc	h es car	dlec or reepl	ratory erreat	,	Approximsta Interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in desth)		Thromboy A CONSEQUENCE OF							Onset and Death
LION	Sequentially liet conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	100	1					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST		A CONSEQUENCE OF	lemen	tiw					
AL	PART II. Other algolificent conditions	s contributing to deeth	but not resulting in	the underlyle	ng ceuse given in	Part I.	24a, WAS AN PERFOR	MED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE
BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH YES		UNCERTAI	— N П	1 TYES 2	NO	OF	DEATH? YES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF DEATH	Check only one)					
PHY	27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpatient 2 ER/Ou 28a. DATE OF INJURY (Month, Day, Year)	28b, TIME	OF 28c. IN	JURY AT ORK?		SCRIBE HOW IF	YJURY OCCUR	ED	
G	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, stc. (Sp	NY — At home, farm, streecify)		YES 2 NO	281. LOC City	CATION (Street e or Town, State)	nd Number or f	Rural Route	9 Number,
COMPLET	44	CIAN: To the best of my kno							suse(e) an	d menner se stated.
O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	r_			29c. LICENSE NUI			29d. DATE SI	1 1	onth, Day, Yber)
-	30. NAME AND ADDRESS OF PERSON WHO	821 Nr		rint)	alhma	·	1021	201		
	DEC1 3 1994	32 REGISTRAR'S SIG	NATURE							

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, I	Middle, Last)						1 2	DATE OF CEATH DO	AY	YEAR	3. TIME OF DEATH
		Jackson						Dec.9,1	994		1:15a M
4. SOCIAL SECURITY NUMBER 213-01-45		5. SEX	8. AGE (In yrs. les		ONTHS DA		HRS. 7	Month Day, Year, Feb. 10,	1912	Country	PLACE (State or Foreign
9a. FACILITY NAME (If not inst	titution, give str	eet and number)		91	b. CITY, TOV	N OR LOCATION	OF DEAT	Н	9c. COUN		
Franklin		Nursir	ng Hom	ie	F	Rossvil	lle		В	alt	imore
10a. STATE Md •	Ba:	ltimore		10c. CITY, T	OWN OR LO	Essex					10d. INSIDE CITY LIMITS? 1 YES X NO
100. STREET AND NUMBER	CO Di	rive				101. ZIP CODE 21221	1			EN OF W	HAT COUNTRY?
11. MARITAL STATUS	T I	12. WAS DECEDENT	EVER IN U.S. AR	MED	13 WAS			ORIGIN? (Specify Yes			- American Indian,
1 Never Married 2 h	200	FORCES? 1	YES 2 1	NO	If yes	, specify Cuban, i YES 2 ⊠ NO	Maxican, I	Puarto Rican, etc.)	0.10-	Black, Specify	White, stc.
15. OECE	DENT'S EDUCA	ATION		CEDENT'S US				16b. KIND OF BUS	SINESS/INDU	JSTRY	
Elementary/Secondary (0-1		College (1-4 or 5+)	life	Do NOT use re	etired.)	most of working		Iro	n Wo	rke	r
17. FATHER'S NAME (First, Mid	Idle, Last)				_	18. MOTHER	R'S NAME	(First, Middle, Maiden			
Jesse		P. Highe	20					Jacks			
19a. INFORMANT'S NAME (Typ		TILU DE		b. MAILING AD	DRESS (Str		-	te Number, City or Tow		Code)	
Alice F				7897	Cha	lice E		Severn	Mar	yla:	nd 21144
1 □ Buriat 2 □ Cremation 4 □ Donation 5 □ Other (3 Ramon	vel from State	cemetery, cre	AND DATE OF E	plece!	,	2/1	3/94 LO	CATION — C		
21. SIGNATURE OF FUNERAL		NSEE	rver	green	22. NAM	E AND ADDRESS	OF FACIL	лу <u>БО</u>	ulsv	111	е ку
· R. T	uu	1 Conn	elly					eral Ho			
23. PART I, Enter the dis	eases, or co	melications that dist only one coue	caused the de	ath. Do not	enter the	mode of dying	, auch a	e cerdiac Dr reepi	ratory arre	et,	
IMMEDIATE CAUSE (Fine		er co all	7		_						Interval Batween Onsat and Death
disease or condition resulting in death)	> a.	Myoca	rdial	Inf	erc	tron					one Day
	-	Myoca DUE TO (O DUE TO (O	R AS A CONSEC	V to VI	· N	5005	0				Vears
Sequentielly list condition if any, leading to immediate	ns,	DUE TO (O	R AS A CONSEC	DUENCE OF):	4 1	1304.					1000
ceuse, Enter UNDERLYIN CAUSE (Disease or injury											
that initieted events resulting in deeth) LAST	1	DUE TO (O	R AS A CONSEC	DUENCE OF):							
	d.			-							
PART II. Other eignifican						ying cause give	en in Pe	rt i. 24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	Alact	Asrtic	77/17	isasia.	NV.	-1.000	(0	_ 1 _ YES 2	LHO		COMPLETION OF CAUSE OF DEATH?
DID TOBACCO US	E CONTRI	tructiv	SE OF DEA	TH VEC	C Y	_		_			1 YES 2 NHO
25. WAS CASE REFERRED TO		DOTE TO CAU		E OF DEATH			CIAIN				
EXAMINER?		HOSPITAL:		0	THER:	tome 5 🗆 Resid	lenca & F	Other (Speciful			
27. MANNER OF DEATH		26a. DATE OF IN (Month, Day,	JURY	26b. TIME O	F 26c.	INJURY AT		d. DESCRIBE HOW II	NJURY OCCU	JRED	
I Decident	ending veatigation			MJURY	M 1	WORK? YES 2 N					
3 Suicide		I 28a DI ACE OF I	NJURY - At ho	me, tarm, stree	et, factory, c	offica	28	t. LOCATION (Street a	nd Number o	r Rural Ro	oute Number,
_ 0 _ 0	ould not be starmined	building, at	c. (Specify)					City or Town, State)			
4 Homicide 29a. CERTIFIER (Check only)	termined	building, at	c. (Specify)	ath occurred a	t the time, o	data and place, an		the cause(a) and man	iner as atated	d.	
29a. CERTIFIER (Check only one) 2 MEDIC.	TYING PHYSICI	AN: To the best of m	c. (Specify) y knowledge, da	investigation, is	n my opinio	n, death occured	nd due to	the cause(a) and man	d dua to the	cause(s)	and manner as stated.
29a. CERTIFIER (Check only one) 2 MEDIC.	TYING PHYSICI	AN: To the best of m	c. (Specify) y knowledge, da	investigation, is	n my opinio	n, death occured	nd due to	the cause(a) and man	d dua to the	cause(s)	
29a. CERTIFIER (Check only one) 2 MEDIC.	TYING PHYSICI	AN: To the best of m	c. (Specify) y knowledge, da	investigation, is	n my opinio	n, death occured	nd due to	the cause(a) and man	d dua to the	cause(s)	
29a. CERTIFIER (Check only one) 2 MEDIC.	PERSON WHO	AN: To the best of m	y knowledge, de mination and/or i OF DEATH (ITER 9000 F	investigation, is	n my opinio	n, death occured	nd due to	the cause(a) and man	d dua to the	cause(s)	and manner as stated. Month, Day, Year) Let 9, 1994 21237

RAI TIMORE MARVI AND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.	
		Harry C. Helmick 2. Date of Death 12-3-94 3. TIME OF DEATH DAY ON ON ON ON ON ON ON ON ON O	DM
2		230 09 7303 5. SEX 6. AGE (In yrs. last birthday) 1 W M 2 F 7	gn
2, 3 should	TOR RO	828 N. Eutaw Street Baltimore 9c. county of Death 9c. county of Death 9c. county of Death 9c. county of Death	
ohysician. burlal-transit permit. Pages 1,	DIRECTO	RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland na Baltimore 1 \Box YES 2 \Box NO	
nsit permit	FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?	,
	BY FUN	11. MARITAL STATUS 1	
or attend	B	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY	
the hospital of detached for once.	COMPLET	College (1-4 or 5+) Made Ink for Printing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)	
ज दे द	BE C	James Wallace Helmick Maddie K. Vest	
be n	2	Mrs Catherine Helmick 308LongIslandAve, F, Baltimore, MD 21229	
nector,		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town, State	
death. e funera		655W.Baltimore St,Balto,MD21201	
with cours at pletely filed in by cremation, or reminent, the medical course of the co		Approximate shock, or heert feliure. List only one cause on each line. Approximate interval Betwoors and Dust Toliga As A Consequence on: Due Toliga As A Consequence on: Due Toliga As A Consequence on:	veeп
certificate be execu- ling physician and ygiene prior to bun other traumatic	RTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (DR AS A CONSEDUENCE OF): DUE TO (DR AS A CONSEDUENCE OF):	2
the atte Mental	L CE	d	NOS
ires that the signed by tealth and we any I	MEDICA	PERFORMED? 1 YES 2 NO PERFORMED? ANALABLE PRIOR TO COMPLETION OF CAUSO OF DEATH? 1 YES 2 NO	
bas b Dept.		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check color one)	
PHYSICIAN: The this certificate the with the State with the Markette the the the the the the the the the	PHYSICIAN:	EXAMINER? 1 YES 2 HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA D	
After death	TED BY	1 Watural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be detarmined 4 Homicide 4 Homicide 6 Could not be detarmined 1 Suicide 8 Could not be detarmined 1 Suicide	\dashv
AL OR AL DIRE	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF CENTURER 29d. DATE SIGNED PROVIDED 29d. DATE SIGNED 29d. DATE	Z
	0	TO HAME AND ADDRESS OF PERSON WOOD COMPLEXED CAUSE OF DEATH (ITEM 27) Printy BOLL BOLL MAYER MAY 21204	
		DEC 13 1994 July d'Audient Randalle	

YSINT SHE YARATE

Sec. 3 94 9 15p

	ANA	Ada A	Alverta	Hor	n	2. DATE OF OEATH MONTH	11-29	-94 3. TIME OF DEA
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	AGE (In yrs. lest birthday,	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		6. BIRTHPLACE (State or F
	217 20 9117	1 🗆 M 2 🖫 F	67 YRS.	MONTHS DAYS	HOURS MIN.	3-16-19:	27	Country) Maryland
стов	90. FACILITY NAME (If not institution, give Bon Secours			9b. CITY, TOWN	Baltimo	EATH	9c. COUNT	TY OF DEATH
DIRECT	Maryland n	а		TY, TOWN OR LOCAL TEMPOR				10d. INSIDE CIT LIMITS? 1 YES 2
AL	100. STREET AND NUMBER 1800 Spenc	e St			21230		10g. CITIZ	EN OF WHAT COUNTRY? USA
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR O	YES 2 NO	If yes,		NIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.) ly:	es or No—	14. RACE — American Ind Black, White, etc. Specify: White
APLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondery (0-12)		16e. DECEOENT (Give kind o ille. Do NOT Homem	s usual occupa f work done during in use retired.) aker	TION most of working	16b. KIND OF BU	USINESS/INDU	
BE COM	17. FATHER'S NAME (First, Middle, Last) William C	. Reely				Me (First, Middle, Meidel May Corni		s
10	190. INFORMANT'S NAME (Type/Print) Robert Silman		19b. MAILIN 8872	2 Town &	end Number or Rural	Blvd-E.E	wn, State, Zip (ottCity,M
	20e. METHOD OF DISPOSITION	manual datase Contra	20b. PLACE AND DATE	E OF DISPOSITION				City or Town, State
	1 Buriel 2 Cremation 3 Re 4 Donetion 5 Other (Specify)	11-2-10-0-2-	cemetery, crematory or					
	21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE Ronald	Wade, Di	1	.Baltim	ore St, B		tomy Boar MD21201
	23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	. List only one cause o	on aach Ilna.		ment	on an cardiac or resp	piratory arre	Approxin interval E Onset an
		DUE TO IGHT	AS A CONSEQUENCE	90:1				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
7		Asperali	on 1	belino	and			14
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR.	AS A CONSEQUENCE	heline OF: Urebro	verscular	. Acrede	nt '	I I A
	If any, leading to immediate	DUE TO (OR C. AULC DUE TO (OR d. CALLIN	AS A CONSEQUENCE, AS A CONSEQUENCE AS A CONSEQUENCE	ording orders ori he	uol vascular M Brio	. Acride	nt '	147
MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	. Carun	ema o) V		Part I. 24s. WAS A	N AUTOPSY DRMED?	24b. WERE AUTOPSY AMAILABLE PRIOF COMPLETION OF OF DEATH? 1 YES 2
SICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition of the condit	one contributing to dear	ema O	In the underly	Ing cause given in	Part I. 24a. WAS AI PERFO	N AUTOPSY DRMED?	AWAILABLE PRIOR COMPLETION OF OF DEATH?
PHYSICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition of the condit	d	end 0 sth but not resulting	26. OTHER: 4 Nursing N. IME OF 28c. I	ing cause given in	Part I. 24a. WAS AI PERFO	N AUTOPSY PRMED? 2 (M) NO	AMAILABLE PRIOF COMPLETION OF OF DEATH!
ED BY PHYSICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition of the condit	d. ALLM one contributing to dee Yell to HOSPITAL: 1 Minpetient 2 = ER/ 28e. DATE OF INJU 26e. PLACE	sth but not resulting	26. OTHER: 4 Nursing H	PLACE OF DEATH (C) PLACE OF DEATH (C) PLACE OF DEATH (C) PLACE OF DEATH (C) PLACE OF DEATH (C) PLACE OF DEATH (C) PLACE OF DEATH (C)	Part I. 24a. WAS AI PERFO 1 YES 1 Other (Specify) 28d. DESCRIBE HOW	N AUTOPSY PRIMED? 2 MNO 2 MNO 2 MNO 2 MNO 2 MNO 2 MNO 2 MNO 3 MNO	AMAILABLE PRIOF COMPLETION OF OF DEATH!
ED BY PHYSICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only)	DONE CONTRIBUTING TO DESCRIPTION HOSPITAL: 1 (1) Inpatient 2 ERVINATION DIV. 16 260. PLACE OF INJ.	sth but not resulting //Outpetient 3 DOA URY 28b. Ti bar) JURY At home, term (Specify) knowledge, death occur	26. OTHER: 4 Nursing Hill ME OF NURY M 1 Interest, fectory, of	PLACE OF DEATH (C) PLACE	Part I. 24a. WAS AI PERFO 1 YES 1 Other (Specify) 28d. DESCRIBE HOW 26t. LOCATION (Street City or Town, Sign	N AUTOPSY PRIMED? 2 MNO	AMAILABLE PRIOR COMPLETION OF OF DEATH! 1 YES 2 URED Or Ruffel Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition of the condit	DONA CONTRIBUTING TO DESCRIPTION OF THE PROPERTY OF THE PROPER	sth but not resulting Voutpetient 3 DOA URY Ser) Voutpetient 3 DOA URY Ser) Voutpetient 3 DOA URY Ser) Knowledge, desth occur instin end/or investiget	26. OTHER: 4 Nursing H ME OF 28c. I NURS M 1 , straet, fectory, of the time, ditten, in my opinion	PLACE OF DEATH (C) PLACE	Part I. 24a. WAS AI PERFO 1 YES 1 Other (Specify) 28d. DESCRIBE HOW 26t. LOCATION (Street City or Town, Sign to the cause(e) end me time, date end place, a	N AUTOPSY PRIMED? 2 (1) NO 2 (AMAILABLE PRIOR COMPLETION OF OF DEATH! 1 YES 2 URED Or Ruffel Route Number,
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Landar Johnson Aure Harry

BALTIMORE, MARYLAND 21215-0020

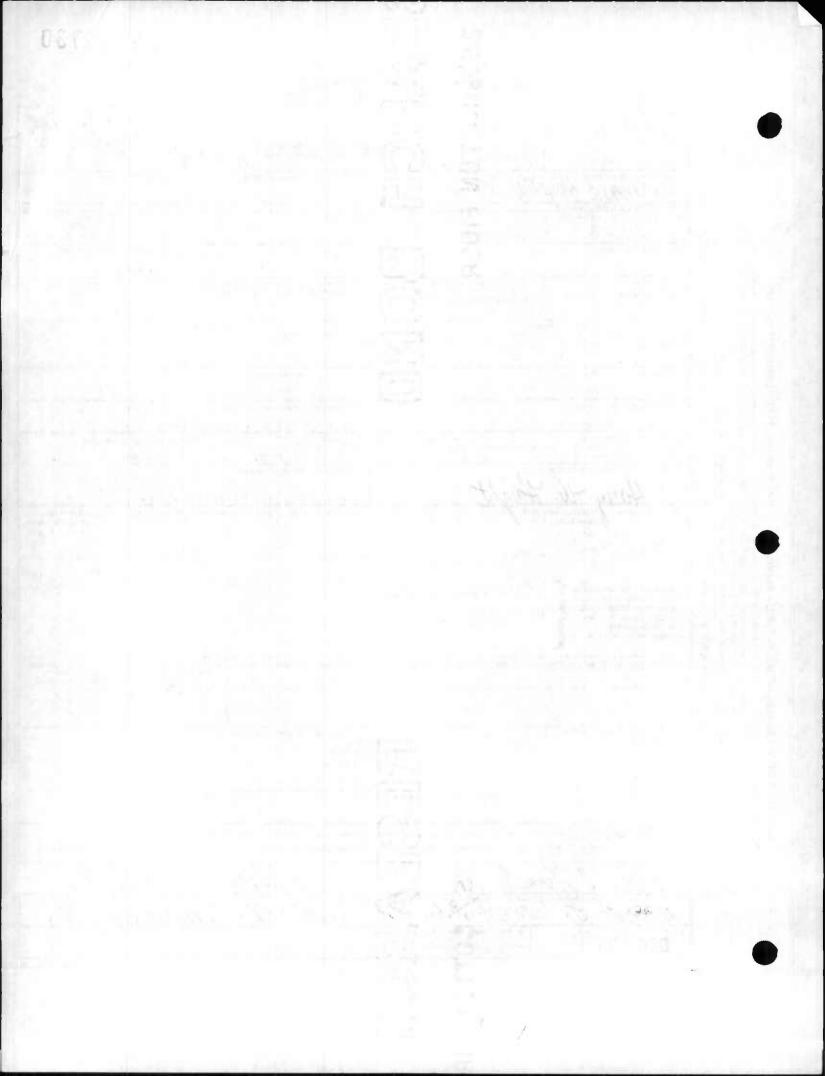
FOR STATE REGISTRAR	STATE OF MARY	YLAND /	DEPAR	TMENT	OF H		AND N	MENTA	L HYGIEI				
1. DECEDENT'S NAME (First, Middle, Lest, WILLIAM		HUDS	SON					2. DATE MONTO	OF DEATH	DAY	94	3. TIME OF D	EATH A
4. SOCIAL SECURITY NUMBER 216 70 5027	1 🔀 M 2 🗆 F	GE (In yrs. last	t birthday) YRS.	IF UNDER	DAYS	IF UNDER 2	MIN.	7. DATE (Monti	of BIRTH h, Day, Year) -194	2	e. BIRTH Count Mai	PLACE (State of y) y) y1and	Foreign
99. FACILITY NAME (If not institution, give UNION AVENUE - RESIDENCE OF DECEDENT						BURY		ATH			COM:		
Maryland Wice	omico Co			ali	sbu	ry						10d. INSIDE C LIMITS? 1 YES 2	□ NO
No fixed addre					101	, ZIP CODE					SA	WHAT COUNTRY	7
11. MARITAL STATUS 1 Never Married 2 Kerried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 _ YI IF YES, GIVE WAR OF	ES 2 N		-	f yes, sp	ENDENT OF ecify Cuben, 2 NO	Mexican	, Puerto I	I? (Specify Ye Rican, atc.)	os or No—	14. RACI Blaci Speci	E — American in k, White, etc. Hy: Whit	
15. DECEDENT'S ED (Specify only highest grad Elementery/Secondery (0-12)		(G/	CEDENT'S ve kind of w Do NOT us	rork done o		ON st of working		16b	. KIND OF BU	JSINESS/INC	DUSTRY		
17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAM	AE (First, I	Middle, Maider	Surname)			
Francis Huds	on _					Haz	e1	Di	shard	on			
190, INFORMANT'S NAME (Type/Print) Mary Jane Hud	son Wi		eafo			nd Number o	or Rural A	oute Numb	ber, City or Tox	wn, State, Zip	Code)		
20e. METHOD OF DISPOSITION 1	noval Irom State	20b. PLACE A	NDDATEC	F DISPOS		me of		DAT	E 20c, L0	OCATION —	City or To	wn, Slate	
21. SIGNATURE OF FUNERAL BERVICE L			,Diı						State St,Ba				
23. PART i. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	Liet only one ceuse or s. ACUTE ETHAN DUE TO (OR A	OL INT	OXICAT	ION	the mo	ae or ayın	g, eucn	es cerc	nec or reep	oratory arr	rest,	Approxi Intervei Onset s	Betwee
Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initisted events resulting in desth) LAST	b. DUE TO (OR A: DUE TO (OR A:												
PART II. Other eignificent condition	ns contributing to death	but not re	eeulting in	n the un	derlying	ceuse giv	ven in F	Part I.	24a. WAS AF PERFO	RMED?	24b.	WERE AUTOPSY AMAILABLE PRIC COMPLETION O OF DEATH?	OR TO
DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEAT	TH YE	<u>. Π ν</u>	10 [UNCE	DTAIN					1 YES 2	NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		E OF DEAT	H (Check o	nly one)	OITCE							
XXYES 2 NO	1 Inpatient 2 ER/O		□ DOA		ing Hom	5 🗆 Resi				STRE			
27. MANNER OF DEATH 1 Natural S Panding	28e. DATE OF INJUR (Month, Day, Year	7)	FOUND	TYPE	28c. INJI WO	RK?			CRIBE HOW	INJURY OC	CURED		
2 Accident Investigation 3 Suicide 8 XX Could not be	FOUND 12-3 28e. PLACE OF INJU building, etc. (S	IRY — At hor	11:58	Pr.		res 🗱		28I. LOC	STION /Street	end Number	or Rurel R	loute Number,	
4 Homicide determined	salising, stc. (o		UND II	YAR)			SALIS	BURY, N	UNION MARYLAN	AVE	-U.S. 13	
	ER: On the best of my kn) end manner es	stated.
296. SIGNATURE AND HILE OF CENTIFIE	1 Chuben	700				29c. LICEN	SE NUME					(Month, Day, Yea	
30. NAME AND ADDRESS OF PERSON W					ceet	t. Ba	alt	imor	ce. M	arvl	and	21201	L
31. DATE FILED (Month, Day, Vear) DEC 13 1994	Philosophia divid					-, -,			-, -,	1-			

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

31. DATE FILED (Month, Day, Your)
DEC 13 1994

32. REGISTRAR'S SIGNATURE

1. DECEDENT'S NAME (First Middle, Leet)	E. HOBBS	(93)			2. DATE	OF DEATH	1/	199	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 216 38 2510	5. SEX 6. AGI		ONTHS DAYS		7. DATE	OF BIRTH 14	8	Counti	ryland
Northurn Wor	ital cente	A I		or location of the last own	EATH /			nty of D	
Maryland (0	v Carroll		TOWN OR LOC						10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER	100	3.67	nksbu	Of. ZIP CODE					1 TYES 2 NO
2346 Bollinge	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DI	21048 ECENDENT OF HISPA	NIC ORIGIN	7 (Specify Yes		S.A.	E — American Indian,
1 Never Married 2XX Married 3 Widowed 4 Divorced	FORCES? 1 X YES		If yes, i	specify Cuban, Mexic S 2xxNO Speci	an, Puarto I			Black	k, White, etc. /// ite
15. DECEDENT'S EDU (Specify only highest grade	completed)	16e. DECEDENT'S US (Give kind of wor life. Do NOT use	k done during r	TION most of working	16b	KIND OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (0-12) H . S .	College (1-4 or 5+)	Construct		spector	St	tate o	f Ma	ryla	nd
17. FATNER'S NAME (First, Middle, Last)		()		18. MOTNER'S N					
Howard Hobbs	500000			Adel1	Par	Lett			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Stree	and Number or Rural	Route Numb	ber, City or Town	r, State, Zij	p Code)	
Joyce Anne Hobbs		2346 Bc	llinge	er Mill F	d. F	inksbu	rg,	Md.	21048
20a. METNOD OF DISPOSITION VC Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	oval from Stata	ob. PLACE AND DATE OF emetery, cremetory or othe Springfiel	pisposition (i	Neme of etery Dec	DAT:	20c, LO	Svk	City or To	own, State
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME	AND ADDRESS OF F	ACILITY				
> 4/an 115	0/ 11/								
23. PART I. Enter the diseases, Dr	complications that caus	ed the death. Do no		Box 195	Sykes		, Md	. 21	
23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inhitated events resulting in death) LAST	S. DUE TO (OR AS	ed the death. Do not sach line. A CONSEQUENCE OF: A CONSEQUENCE OF:	t enter the m		Sykes	sville	, Md	. 21	784 Approximate Interval Between
shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	S. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF):	S S	THE U	Sykes ches card	sville	, Md ratory ar	. 21 rest,	784 Approximate interval Betwee Onset and Des
shock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition	S. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF):	the underlyl	THE U	Sykes ches card	SVIlle Hec or resplication of the second sec	Md ratory ar	. 21 rest,	Approximate Interval Betwee Onset and Dys Monday American Dys Markable PRIOR TO COMPLETION OF CAUSE OF DEATH?
shock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF:	the underlyl	ng couse given in	Sykes ches card	24a. WAS AN. PERFOR 1 YES 2	Md ratory ar	. 21 rest,	Approximate Interval Betwee Onset and Dys Monday American Service Autops Y Finding American To Completion of Cause of Death?
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATH 1 Natural 5 Pending	b. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in	the underlyl 26. DTHER: Nursing No	THE U	Sykes ches card	24a. WAS AN. PERFOR 1 YES 2	AUTOPSY NO	. 21 rest,	Approximate Interval Betwee Onset and Dys Monday American Service Autops Y Finding American To Completion of Cause Of Death?
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Placese or Injury that initiated events resulting in death) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER of DEATH 1 Natural 5 Pending Investigation 3 Suicide 5 Could not be determined 29a. CERTIFIER Check only	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF: Dut not resulting in Ripatient 3 DOA 4 (1) 26b. TiME (1) RY — At home, farm, streecity)	the underlyl 26. THER: Nursing No. NY M 1 = 28c. If	ng ceuse given in place of DEATH (Come 5 Residence VORKY if YES 2 NO lice	Sykes ches card	24a. WAS AN. PERFOR 1 YES 2 ATION (Street a or Rown, State)	AUTOPSY MED? NO	24b	Approximate interval Betwee Onset and Def Monday Approximate interval Betwee Onset and Def Monday Interval Betwee Onset and Def Monday Interval Int



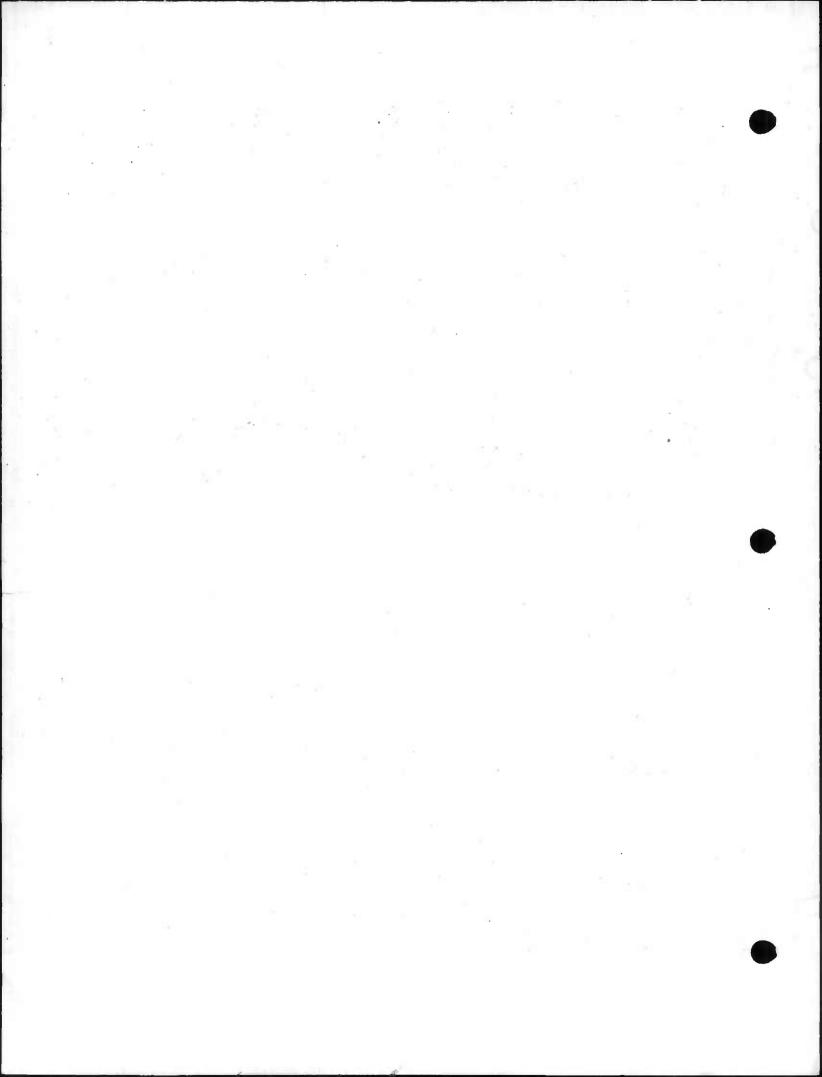
BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely fill

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; IMPORTANT: If I lem 28 is marked, or Item 23 shows any Iniury, or other traumatic and the properties of the prop

DR DENNIS
31. DATE FILED (Month, Day, Year)
DEC 13 1994

HANNON

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.														
		1. DECEDENT'S NAME (First, M	iddle, Last)										ATE OF DEATH			3. TIME OF DEATH
		Philli	Sandys		Ire	У					MONTH DAY YEAR 11-24-94 5:2			5:25 P M		
	-	4. SOCIAL SECURITY NUMBER	. SECURITY NUMBER 5. SEX 8. /					IF UNDER		IF UNDER	1	7. D/	ATE OF BIRTH			IPLACE (State or Foreign
		579 10 38	8	2	YRS.	MONTHS	DAYS	HOURS	WIN.	3-25-1912 Wash,		h, DC				
Ш.	١	Se. FACILITY HAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH														
l c		Sandy Springs Retirement Comm Sandy Springs Montgomery Co														
5		RESIDENCE OF DECE	DENT 0b. COUNTY	,			40. 0171	, TOWN O	4			=				
DIRECTOR				gomery (7.0						20					10d. INSIDE CITY LIMITS?
		Maryland Montgomery Co Sandy Spring 100. STREET AND HUMBER 101. ZIP CODE 109. CITIZEN OF WHA										1 YES 2 HO				
FRAI		17330 Quaker Lane #5 20862 USA														
FUN		11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or Ho — 14. RACE — American Indian,										E — American Indian				
		t Never Married 2 Me		FORCES? 1 IF YES, GIVE W	YES	27 H		t t	f yes, sp		en, Mexica	n, Pue	erto Rican, etc.)	0,110-	Black	k, White, etc.
B	- 11	3 Widowed 4 Divorce	id .							2 100	ориску			- 1	apec	White
COMPLETED		t5. DECED (Specify only hi	EHT'S EDUC	CATION completed)		(Gi	CEDENT'S	ork done o	CCUPATI	OH ost of working	na	T	16b. KIND OF BUS	INESS/IND	USTRY	
<u> </u>		Elementery/Secondary (0-12)	College (1-4 or 5	-)	life.	Do NOT us	retired.)			•					
9 B		12+		8			Dent	ist				\perp				
E 8		17. FATHER'S NAME (First, Middle											rst, Middle, Malden			
ed a		Edwin Sar		Trey		401	*****					aret Scudder Rural Route Number, City or Town, State, Zip Code)				
夏 日			wermu)													WD00000
9		John Irey 2712 Plyers Mill Rd, SilverSprings, MD20902														
must	i	20e. METHOD OF DISPOSITION 20b. PLACE AHD DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State														
Jer I		11 SIGNATURE OF UNERAL SERVICE LICENSEER on ald Wade, Dir 22 NAME AND ADDRESS OF FACILITY State Anatomy Board														
examiner must be notified at once.		655W.Baltimore St, Balto, MD21201														
the medical		23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart fallure. List only one cause on each line. Approximate intervel Between														
E .	U	IMMEDIATE CAUSE (Final										Onset and Death				
5		disease or condition resulting in death) a. PROSTATE CANCER 2 4rs														
other traumatic event,		DUE TO (OR AS A CONSEQUENCE OF):														
S g		Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):														
r other traumatic		cause. Enter UNDERLYING														
힐		CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):														
- I I		resulting in death) LAST														
걸	- 11	DADT II Other classificant and distance contribution to the state of t														
		PERFORMED? AVAIL											WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
MEDIC											OF DEATH?					
		t YES 2 NO														
S Z		25. WAS CASE REFERRED TO M	AEDICAL T													
SIC!		EXAMINER? 1 YES 2 NO	LDIOAL	HOSPITAL:	l en rous			OTHER	R:	LACE OF D			-			
ँ । ≥		27. MANNER OF DEATH		1 Inpatient 2	INJURY	Patrietti 3	28b. TIME			JURY AT	esidencs	_	Other (Specify) DESCRIBE HOW II	JURY OCC	URED	
marked, BY PF		1 Natural 5 Per	nding	(Month, D	ay, Year)		ILNI	JRY M	WC	YES 2	□ NO					
E 0	- 11	2 Suleida	uld not be	28e. PLACE O	FINJURY	— At ho	me, ferm, s	treet, facto	ory, offic	e			LOCATION (Street e	nd Number	or Rural I	Route Number,
28 LE			ermined	building,	etc. (Spe	cny)							City or Town, State)			
의 본		29e. CERTIFIER (Check only	YING PHYSIC	CIAH: To the best of	my know	ledge, de	eth occurre	d at the ti	me, date	end pince	, end due	to the	cause(s) end men	ner as atat	ed.	
ANT: If its		2001														s) end menner es stated.
E C	- 10	296, SIGHATURE AND TITLE OF	F CERTIFIER	N.					_	29c. LIC	ENSE NUN	ABER		29d. DATE	E SIGNED	(Month, Day, Year)
O BE COM		Wenn 1	M, 1	tam	m	M)			D	77	17	4	 	1-2	0-94
- 2		30. HAME AND ADDRESS OF P	ERSON WHO	COMPLETED CAUS	E OF DE	ATH (ITE	1 27) (Type,	Print)				-		- (1 ~	



3. TIME OF DEATH

1 YES 2 X NO

8. BIRTHPLACE (State or Fornigo

VIRGINIA

9c. COUNTY OF DEATH

Baltimore

10g, CITIZEN OF WHAT COUNTRY?

USA

Specify:

14. RACE — American Indian, Black, White, stc.

WHITE

BLESSING

Approximate

interval Betw

Onset and Death

hours

days

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO

COMPLETION OF CAUSE DF DEATH?

1X YES 2 □ NO

▶ 12/12/94

- GBMC - 6701 N. Charles Street, Baltimore MD

5:57 A

2. DATE OF DEATH

FOR STATE

REGISTRAR

1. DECEDENT'S NAME /First Middle Last

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P.0
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2

December 12, 1994 Mildred Elizabeth Jones 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. MAY 19, 1912 DAYS 1 M M M T 216-12-2698 use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Greater Baltimore Medical Center Towson RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION BALTIMORE MARYLAND LUTHERVILLE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 209 TUFTS ROAD 21093 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) FORCES? 1 YES 2 NO 1 Never Married 2 Married BY 1 TYES 2 NO Specify: 3 🔀 Widowed 4 🗌 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15 DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) page 5 should be detached for HOUSEWIFE 8 AT HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Ħ FIELDEN BE LINDAMOOD notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JOHN FRAZIER 2 MANOR BROOK ROAD MONKTON, MD. 21111 nurs after death. Page 6 may be Pe 29a METHOD OF DISPOSITION
1 Burlal 2 □ Cremation 3 □ R 20b. PLACE AND DATE OF DISPOSITION (Name of 26c. LOCATION -- City or Town, State DATE must filled in by the funeral director, on, or removal. DULANEY VALLEY CEM. 12/15/94 4 Donation 8 Other (Specify) TIMONIUM, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN E. DOLAN 22. NAME AND ADDRESS OF FACILITY 06 RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204 medical 23. PART /. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) and completely fit burial, cremation Possible sepsis within event, DUE TO (OR AS A CONSEQUENCE OF): executed Acute colitis traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING been signed by the attending physician at on Health and Mental Hygiene prior to 90 certificate CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. the MEDICAL 24a. WAS AN AUTOPSY that shows any 1 XYES 2 NO PHYSICIAN: certificate has be 23 25. WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATH (Check only one) tem HOSPITAL:
|| Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO PHYSICIAN: 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28c. INJURY AT WORK? By PH 28a, DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY ij ä 1 Netural
2 Accident 5 Pending Investigation I YES 2 NO ALTENDING After 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 5 Could not be determined 4 Homicide 8 29e. CERTIFIER

Check nate 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(e) and manner as stated. FUNERAL I COMP HOSPITAL TO THE HOSPITATO THE FUNESPA DE filed within 7. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D36226 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

32 REGISTRAR'S SUNATURE

Ludwig

Rebecca A.

DEC1 3 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	2
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DECT 3 1994

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Las 2. DATE OF DEATH 3. TIME OF DEATH 10 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS DAYS 9b. CITY, TOWN OR LOCATION OF DEATH COMPLETED BY FUNERAL DIRECTOR 10b. COUNTY 10d. INSIDE CITY ATONS i 1 TES 2 NO 10g. CITIZEN OF WHAT COUNTRY? . WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Guban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. If yes, specify Cubs
1 YES 2 NO 1 Never Married 2 Married
3 Wildowed 4 Divorced Specify: 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUSTRY (Specify only highest grade comple ndary (0-12) College (1-4 or 5 +) ASSITATION ENGINEEL **BE** 0 20a METHOD OF DISPOSITION
1 Burlal 2 Cremation
4 Donation 3 Donation 5 Other (Specify) Kollle 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximata shock, or haart failure. List only one cause on each line. Intarval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) ayo PHYSICIAN: MEDICAL CERTIFICATION Sequantially list conditions, A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING 6 000 S CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST arc-inoug PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 26d. OESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, term, strest, tectory, office building, stc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(s) and manner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 8 29d. DATE SIGNED (Month, Day, Year) Solles survo 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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ALC: NOTE IN

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-tragest permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burla, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

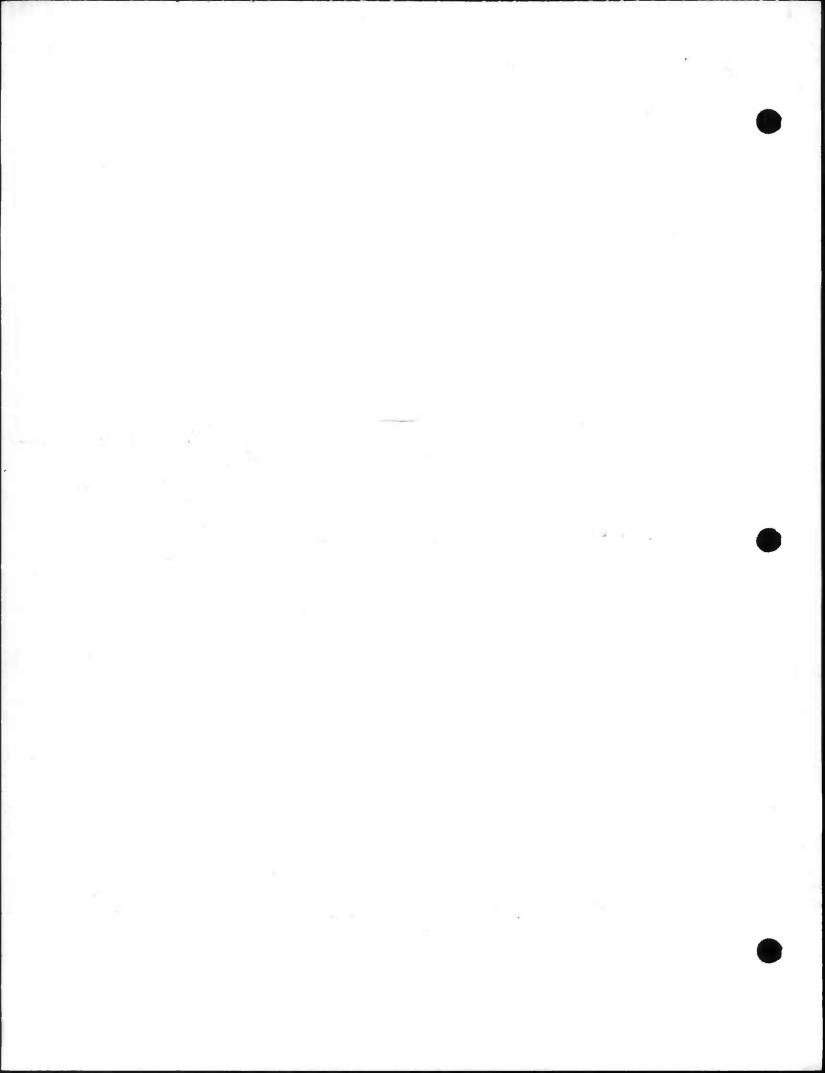
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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PER F.H. FILM G-718 12/13/94 t.t

STA	TE OF	MARYL	AND /	DEPAR	RTMENT	0F	HEALTH	AND	MENTAL	HYGIE	NE
							F DEAT			REG NO	

	REGISTRAR	CE	RTIF	CATE OF	DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) DELORES P. JONES 2. DATE OF DEATH MONTH 12-11-94										
BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 177-46-9121 1 □ M 2 🔀	BIRTHPLACE (State or Foreign Country) Maryland									
	9a. FACILITY NAME (If not Institution, give street and number) 2201 Cecil Ave. Balto. City None										
	Maryland None Balto. City										
	2201 Cecil Ave.			101	101. ZIP CODE 21218 10g. CITIZEN OF W United 13. WAS DECENDENT OF HISPANIC ORIGIN7 (Specify Yea or No						
	XIX Never Married 2 Married FORCES?	DENT EVER IN U.S. ARI 1 YES 2 N E WAR OR DATES	MED	Black, White, etc. Specify:							
TEO	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY										
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) Mone Never Worked None										
6 III	Floyd Jones, Sr.					nia Lee		22			
18	19a. INFORMANT'S NAME (Type/Print)	198	. MAILING	ADDRESS (Street e		Route Number, City or Tow					
2	Evelyna Nutter		ee):	- 2201	Cecil A	Ave. Bal	to, M	Md. 21218			
1891	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Complex) complex										
TO BI	21. SEGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate										
	anock, or heert feiture. List only one ceuse on each line.										
	resulting to death)										
TIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): Chronic Hepatits DUE TO (OR AS A CONSEQUENCE OF):										
FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events C. Due tro (OR AS A CONSEQUENCE OF):										
5 I III	reculting in death) LAST										
DICAL CI	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24s. WAS AN AUTOPSY PERFORMED? #										
ш						1 YES 2	(A-No	OF DEATH?			
Z	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEA	TH YE	S NO C	UNCERTAIN	4 D					
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:			H (Check only one) OTHER:							
		2 ER/Outpetient 3	□ DOA	4 - Nursing Hom	5 Residence						
TED BY PH	27. MANNER OF DEATH 1							IED			
	3 Suicide 6 Could not be 4 Homicide datarminad 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Yown, State) 26f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)										
BE COMPLETED	29a. CERTIFIEN (Check only) one) 1 CERTIFYING PHYSICIAN: To the bes							ause(a) and manner as stated.			
TO BE C	290- SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dev. You) 12/12/94										
F	RE CHAISSON, MP JOHNS HOPKINS HOSP										
	DEC13 1994	HAR'S SIGNATURE									



Ē	IVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
3	ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician.
4	R: After this certificate has been signed by the attending physician and completely fille	The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Planes 1, 2, 3 should
E	In the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	or removal.
Si I	in marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH DAY
DECEMBER 3. TIME OF DEATH Martha E. ones 2:45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 11715/1932 IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 222-18-4880 1 - M 2 M F 62 DAYS HOURS Cannon, Delaware YRS 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10e STATE 105 COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Delaware Sussex Bridgeville 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101. ZIP COOE 10o. CITIZEN OF WHAT COUNTRY? 109 Delaware Avenue 19933 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)
 T YES 2 NO Specify: 14. RACE — American indian, Black. White, atc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Clim kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Elementary/Secondary (0-12) 11th Cafeteria Worker School District 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Raymond Hastings Rachel Hastings BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Douglas C. Jones R.D. 2, Box 26 AB - Bridgeville, DE 19933 20a METHOD OF DISPOSITION
1 M Burlel 2 Cremetton 3 Removal from State
4 Donetto 5 Other (Span) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE comparing eville Cemetery 12/9 Bridgeville, Delaware 5 Other (Special) OF FUNERAL SE Yardesty Funeral Home-202 Laws St. Bridgeville, DE 19933 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert fellure. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Finei** Onset end Death disease or condition cule resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa reaulting in deeth) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpution 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 AND 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 -Nitural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 3 Suicide 6 Could not be 4 Homicide 29e. CERTIFIER

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1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation; in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) einamin

Quincy + Locust Sts.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PEATH (ITEM 27) (Type, Print)

Benjamin

Salisbury MD

BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with chours after death. Page 6 may be retained by the hospital or attending physic	
	nours after	
	7	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	w requires that the death certificate be executed with	
ISION OF VITAL	TENDING PHYSICIAN: The law	

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

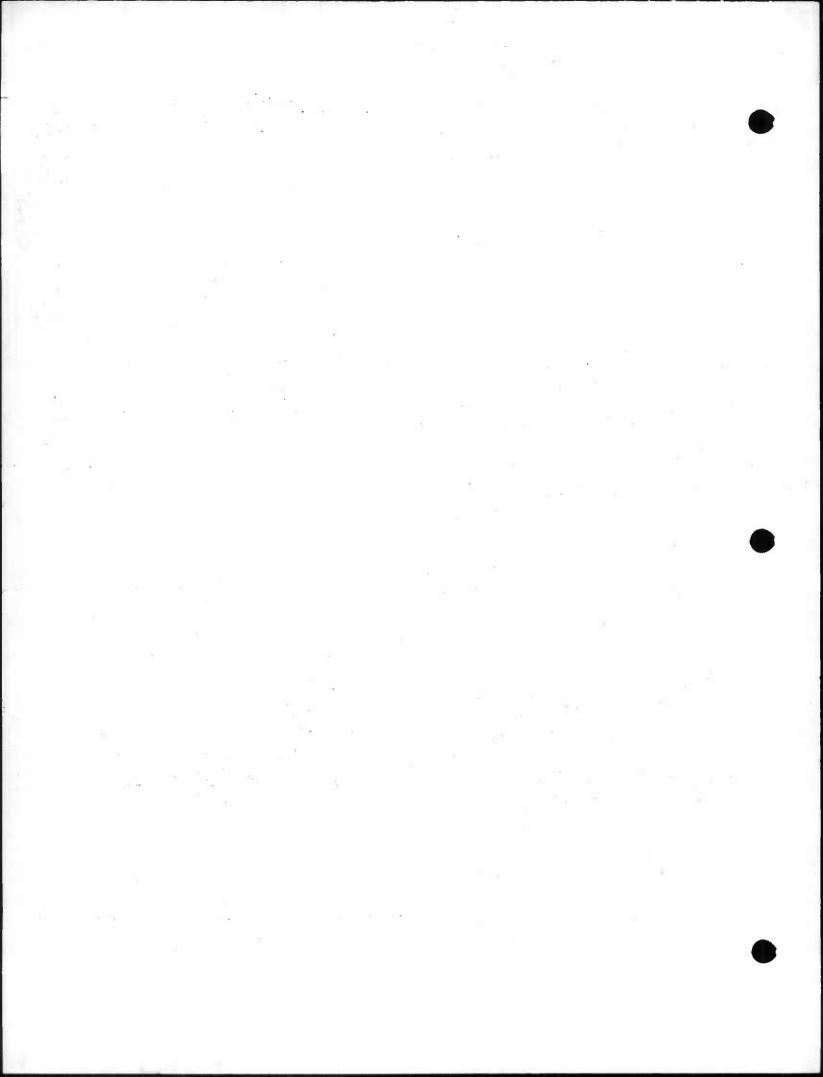
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR	CTATE OF A	FADVI AND /	DEDAD	TAICH	T OF U	PAITU	490 (J.*	1 0	010
	1 - STATE REGISTRAR	SIMIE UF I		ERTIF					MENTAL HYGIE REG. N			
	1. OECEDENT'S NAME (First, Middle, Last)							14	2. DATE OF OEATH	DAY	YEAR 3. 1	TIME OF DEATH
	PATRICIA J	JEANNE	JACO	DBS					11-30-9		YEAH	3:20P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIRTH (Month, Day, Year)	T	8. BIRTHPLA Country)	CE (State or Foreign
	205 20 0891	1 🗆 M 2 🖳 🗜	69	YRS.	MONTHS	DAY8	HOURS	MIN.	(MOINII, LPay, rous,			ylvania
	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CIT	Y, TOWN C	R LOCATI	ON OF DE	ATH		TY OF DEATH	
OR	12601 Penten	ville R	oad		Si1	ver	Spi	ring	S	Mont	gomei	ry County
DIRECTOR	RESIDENCE OF DECEDENT									110111		
뿔					Y, TOWN	OR LOCAT					10d	1. INSIDE CITY LIMITS?
	Maryland Mont	gomery	County	<u> </u>					Springs			YES 2 NO
FUNERAL						101	. ZIP COD			10g. CITIZ	ZEN OF WHAT	COUNTRY?
E E	12601 Penten					1 3	209		USA			
<u> </u>	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13.				IIC ORIGIN? (Specify Y	ea or No-	14. RACE - / Black, Wh	American Indian, hite, atc.
B√	3Widowed 4 Divorced	IF YES, GIVE W					2 NO			-	Specify:	ite
	15. DECEDENT'S EDUC	PATION	n o	CEDENT'S	Hellal C	COLIDATIO	M4		16b, KIND OF B	100,000		лте
	(Specify only highest grade	completed)	(G	ive kind of a	work done	during mo:		ng	160, KIND OF B	USINE35/INDI	JSTHY	
12	Elementary/Secondary (0-12)	College (1-4 or 5 +	•)	Hom								
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			nom	ema	кет	18 MOTI	MED'S MA	ME (First, Middle, Maide	a Cumama!		
		C	w .				_				1 1	
BE	John Charles 19a. INFORMANT'S NAME (Type/Print)	Sycamo		h MAILING	ADDRES	e (Ctmat e			Ce F	arrel		
2	Pamela Jacobs										,	1000
9	20e. METHOD OF DISPOSITION		20b. PLACE					Lane	DATE 20c. L	OCATION — C		
	1 Buriel 2 Cremation 3 Remo		cemetery, cre	matory or o	ther place	,				ocation — c	illy or Town,	Stata
CYGIIII	21. SIGNATURE OF FURERAL SERVICE LICE	Cocce Rona		e,Di		55W			ore St,I			Board 201
	23. ART I. Enter the diseases, or co	omplications the	t caused the de	ath. Do i	not ente	r the mo	de of dy	ing, suci	h ee cerdiac or ree	piratory arre	eet,	Approximate
	ahock, or heart fellure. I							Λ				Interval Between Onset and Death
	disease or condition resulting in death)	Cdvol	is Ne	1/2	Ly.	262	. /	(1)	-est		j	10 n. 4.
	resulting in death)	DUE TO	(OR AS A CONSEC	OUENCE O	F):	7		· · /				,
Z		51	5P 51	5								12hour
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	h										
	that initiated eventa	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
	resulting in deeth) LAST	1.										
i O	PART II. Other significent conditions	s contribution to	death but not a	onultino.	in the co	a da dula d		-1	Book I as una		1	
MEDICAL		. commoning to	deadl but libt i	oouning	m uie u	iluerryitiş	J cause i	Aiseil III		N AUTOPSY ORMED?	AM	RE AUTOPSY FINDINGS FLABLE PRIOR TO
									1 □ YES	2 100		MPLETION OF CAUSE DEATH?
											1 [YES 2 NO
Z												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		ACE OF D	EATN (Che	ack only one)			
- X	1 YES 2 X40	1 Inpatient 2		□ DOA			5 XA	aldence	6 Other (Specify)			
P. H	27. MANNER OF DEATN 1	286. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED WORK?								URED		
B	2 Accident Investigation	M 1 YES 2 NO										
ا م ا	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, streat, factory, office building, stc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)									Number,		
ETE	4 Nomicide datermined											
COMPLETE		ZIAN: To the best of	my knowledge, da	ath occum	ed at the	time, data	end placa	, and dua	to the cause(a) and m	enner ee state	ıd.	
O.	one) 2 MEDICAL EXAMINER											d manner se stated.
E O	TURE AND TITCE OF CERTIFIER	1	1.				29c. LICI	ENSE NUM	ABER	29d. DATE	SIGNED (Moi	rith, Day, Year)
	Mussellt.	full	ans				5		232		2-1.	2000
[일	MAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	DE OF BEATH STEE	M 070 /5	Defeat		1/	0 4			/-	17

PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

31. DATE FILED (Morith, Day, Year)
DEC 13 1994

1299 Lamberton Drive, SilverSprings, MD20902



BALTIMORE, MARYLAND 21215-0020	ge 6 may be retained by the hospital or attending physician.	irrector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	r must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within seriours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR				CER	TIFIC	CATE	OF	DEA	TH		REG. NO).		
1. DECEDENT'S NAME (First, I RANDOLPH	Jame	s J	OHN	SON						2. DATE MONT OC	OF DEATH	AY 2 4	94	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBE 214 12 88	2.2	5. SEX 1 [X M 2] F		n yrs. lest bir		F UNDER 1	YEAR DAYS	IF UNDE	R 24 HRS.	7. DATE	of BIRTH			HPLACE (State or Foreign
											.0 23	,		
9a. FACILITY NAME (If not inst 1701 EUTAV					1	96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY						9c. COUNTY OF DEATH I) 2		
RESIDENCE OF DECEDENT														
Maryland	na na			1	Ba.	rown on ltin								10d. INSIDE CITY LIMITS? 1 YES 2 NO
1701 Eutav	w Str	eet		1			101	zip cod	DE 1217	7		10g. CIT	IZEN OF	WHAT COUNTRY?
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE — American Indian.														
1 Naver Married 2 Merried 3 Widowed 4 Divorced Naver Married 2 Merried Widowed 4 Divorced Naver Married 2 Merried Naver Married 2 Merried Naver Merried 2 Merried Naver Merried 3 Merri						11	yes, sp		en, Maxica	en, Puerto	N7 (Specify Ye Rican, atc.)	e or No	14, RAC Blac Spec	k, White, etc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY														
17. FATHER'S NAME (First, Mid	Idla Laasi					-								
17. PATHER'S HAME (PIST, MIC	ore, Last)							18. MOT	HER'S NA	ME (First,	Middle, Maider	Sumame)		
19e. INFORMANT'S NAME (Typ.	oe/Print)			19b. M	AILING A	DDRESS (Street a	and Numbe	or Rural	Route Num	ber, City or Tox	vn, State, Zij	p Code)	
20s. METHOD OF DISPOSITION 1								own, State						
21. SIGNATURE OF FUNERAL	SERVICE LICE	NSEE	1 11	- 1 -	D 2	22. N/	AME AN	NO ADDRE	SS OF FA	CILITY				n ,
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir Asept B														
ahock, or had														
Sequantially list condition if any, leading to immedicause. Entar UNDERLYIN CAUSE (Disease or Injury that initiated avents resulting in death) LAST	ata G			CONSEQUE										
PART II. Other algnifican	t conditions	contributing to	death bu	it not reau	iting in	the und	arlying	g causa	given in	Part I.	24a. WAS AN PERFO		24b	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
DIABETES											1 TYES	XXNO		COMPLETION OF CAUSE OF DEATH?
DID TOBACCO US	E CONTR	BUTE TO CA	USE OF	F DEATH	YES	Пи	0 [1 UNG	CERTAII		Inq	uiry		1 TES 2 NO
25. WAS CASE REFERRED TO				6. PLACE O	_			. 5110						
EXAMINER?		HOSPITAL:	T 400 Per	H. C		THER:	-	.75						
27. MANNER OF DEATH		1 Inpatient 2 28a. OATE OF	_			- Y			asidence	6 Othe				
1√√Netural 5 ☐ Po	ending vestigation	(Month, D		28	D. TIME (WO	URY AT PK? YES 2 [NO NO	28d. OE:	SCRIBE HOW	INJURY OC	CURED	
3 Suicide 8 C	ould not be starmined	28a. PLACE O building,	F INJURY - atc. (Specif	— At homa,	farm, atre	et, factor	y, offici				ATION (Street or Town, State		r or Rural I	Route Number,
		IAN: To the best of												i) and manner as stated.
	F CERTIFIER					-					,,			
Wario	hey	rell							C M		- 5			(Month, Day, Year) O-94
30. NAME AND ADDRESS OF THE STATE OF THE STA	PERSON WHO	COMPLETED CAUS					ree				re, l	Mary	land	1 21201
31. DATE FIRE ZICHITTS	394	Jub 2 do	P'S SIGNA	Marke	4									

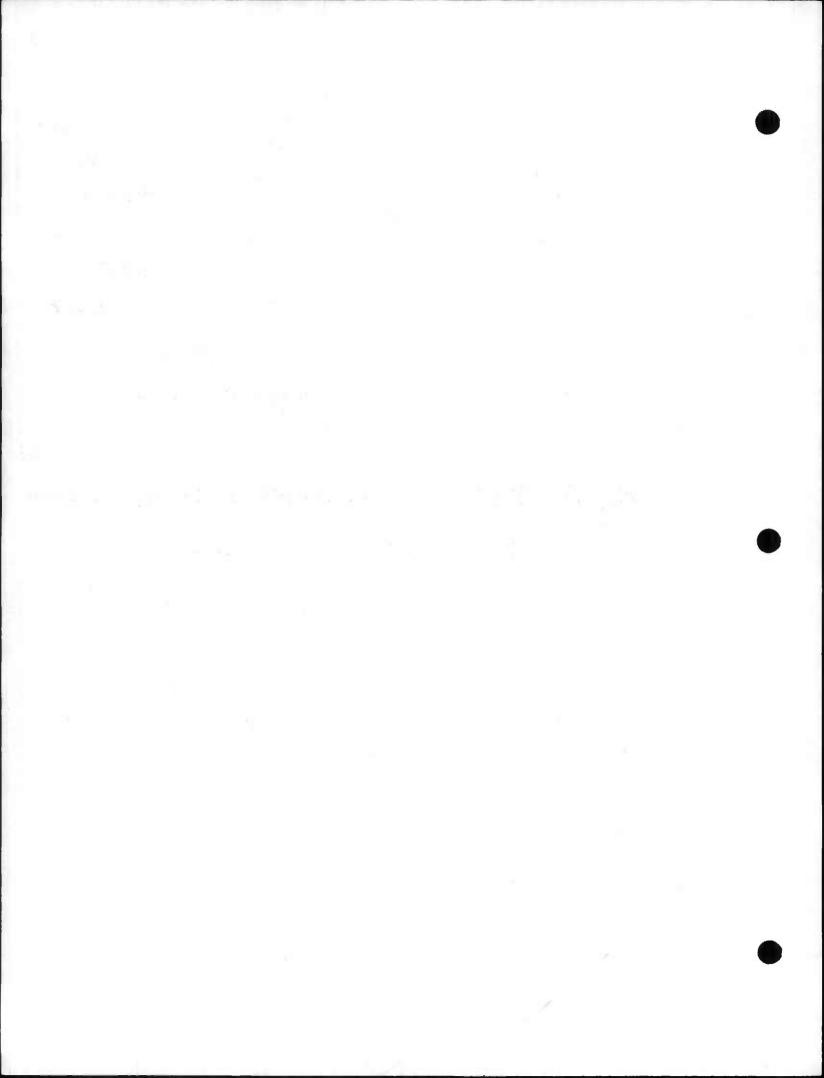
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

		TIEGIOTTIAN		- CL	-MITTE	AIL OF	DEATH	HEG. NO	•				
		1. DECEDENT'S NAME (First, Middle, Last)	4 m = 1 m + 1	T .				2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH					
		Rosie El	7	JONNS 6. AGE (In yrs. lest		F UNDER 1 YEAR	IF UNDER 24 HRS.	Dec. 6	1				
D		214 38 7388	1 🗆 M 2 💢 F	74		ONTHS DAYS	HOURS MIN.	(Month, Day, Year)	8.8	BIRTHPLACE (State or Foreign Country)			
pinous		9e. FACILITY NAME (If not institution, give s	treet end number)			b. CITY, TOWN	OF DEATH						
1, 2, 3	DIRECTOR	Lorien RESIDENCE OF DECEDENT	Nursing	g Home		Colum	bia		Hol	WARD			
ages	띮	10e. STATE 10b. COUNTY	1		10c. CITY, 1	TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?			
permit. Pages		Md. How	ard		Co1	Lumbia				1 - YES 2 - NO			
<u>st</u>	FUNERAL	100. STREET AND NUMBER 7176 Peace C	himes Co	ourt		10	1. ZIP CODE 21045		10g. CITIZEN	OF WHAT COUNTRY?			
physician. burial-transit	15	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	MED	13. WAS DEC	CENCENT OF HISPA	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	n or No— 14.	RACE — American Indian, Black, White, etc.			
	B	1 Never Merried 2 Merried 3 XWidowed 4 Divorced	IF YES, GIVE WAR				X NO Specif			Specify: Black			
r attending use as the	TED	15. DECEDENT'S EDU (Specify only highest grade		(Gh	ve kind of won	SUAL OCCUPATION done during mo	ON ost of working	16b. KIND OF BU	SINESS/INDUST	RY			
spital or hed for	IPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		memak	Design		Hoi	ne-				
the hospital detached 1 once.	COMP	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maiden	Surneme)				
ad be	BE	Robert H. And	erson				VIRGIY		phond				
5 should	2	19e. INFORMANT'S NAME (Type/Print)					U	Route Number, City or Tow	m, State, Zip Coo	(e)			
ay be		Earl Sylvester 20m. METHOD OF DISPOSITION	Anderso		_	Basket DISPOSITION (No	Ring		CATION — City	or Town State			
age 6 ma director, p er must		tX Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cres	natory or other	r place)	Cemet		1994	Highland, Md			
funeral funeral examin		21. SIGNATURE OF FUNERAL SERVICE LIC	Haralt			Pris A	ND ADDRESS OF FA	- HAigh	+ Fun	my none			
d in by the or removal.		23. PART I. Enter the diseases, or o	complications that	caused tha da	nth. Do not	antar the mo	oda of dying, aud	th as cardisc or resp	iretory arreat,	Approximate			
ly filled ir ation, or the me		shock, dy heart fallure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Asm	vat	Len	pn	eun	orin		Interval Between Onset and Daath ACULE			
executed within and complete o burial, crem: matic event,	_		DUÉ TO (O	OR AS A CONSEC	UENCE OF):	dis	Soudon	-		Years			
be or t	RTIFICATION	If any, leading to Immediate clause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) Property of the Consequence of the Cons											
phy ne p	IFIC	CAUSE (Disease or Injury that initiated avents	DUE TO (O	OR AS A CONSEC		- 100	vas4/		7~3.5				
attending mtal Hygie Y, or otl	CERT	resulting in death) LAST d. Dubetes Mellitus. 11eus.											
The of		PART II. Other eignificant condition	s contributing to d	aath but not re	aulting in	tha undarlyln	g cause given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS			
signed by Health and Ws any i	EDICAL							PERFOR	10	AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?			
een sign of He	Σ	DID TORACCO LICE (COLITRIBUTE	TO CALL			(FO FF) 1.00			1 WES 2 NO			
has b Dept.	SICIAN:	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL	ONIKIBUTE	IO CAUS	E OF L		ES NC	المز		N/H.			
AN: The	SIC	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ 00A \$	THER:		6 Other (Specify)					
PHYSICI, this cert with the	РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF IN (Month, Day,		28b. TIME O	OF 28c. INJ	JURY AT DRK?	28d. OEŞCRIBE HOW I	NJURY OCCURE	D			
After death	р ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At hor	ne, farm, stre		YES 2 NO	28f. LOCATION (Street		ural Route Number,			
R ATTEN RECTOR. Ins after m 28 i	ETE	4 Homicide determined	building, et	ic. (Specify)				City or Town, State)		THE DI TORON			
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires I TO THE FUNEPAL DIRECTOR: After this certificate has been signe be filed within 72 hours after death with the State Dept. of Health IMPORTANT: If Item 28 is marked, or Item 23 shows a	COMPL							to the cause(e) end main time, date end place, er		use(e) end menner ee stated.			
O THE H o filed w	BE	291 SIGNATURE AND TITLE OF CERTIFIER	hille	nu		29c. LIGENSE NUMBER 29d. DATE SIGNED (Month, Day, Yold) 29d. DATE SIGNED (Month, Day, Yold) 29d. DATE SIGNED (Month, Day, Yold)							
	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUGH OF DEATH (ITEM 27) (Type, Print) KOCOD RUBETT 950/ OLD Arrepolis Road Ellicott City MD 21042											
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE		yw-w	16844	0/11/011	uy n	NW ZIVYE			
		nfc 1 3 1994	Junio Dandson	-Rendall						1			



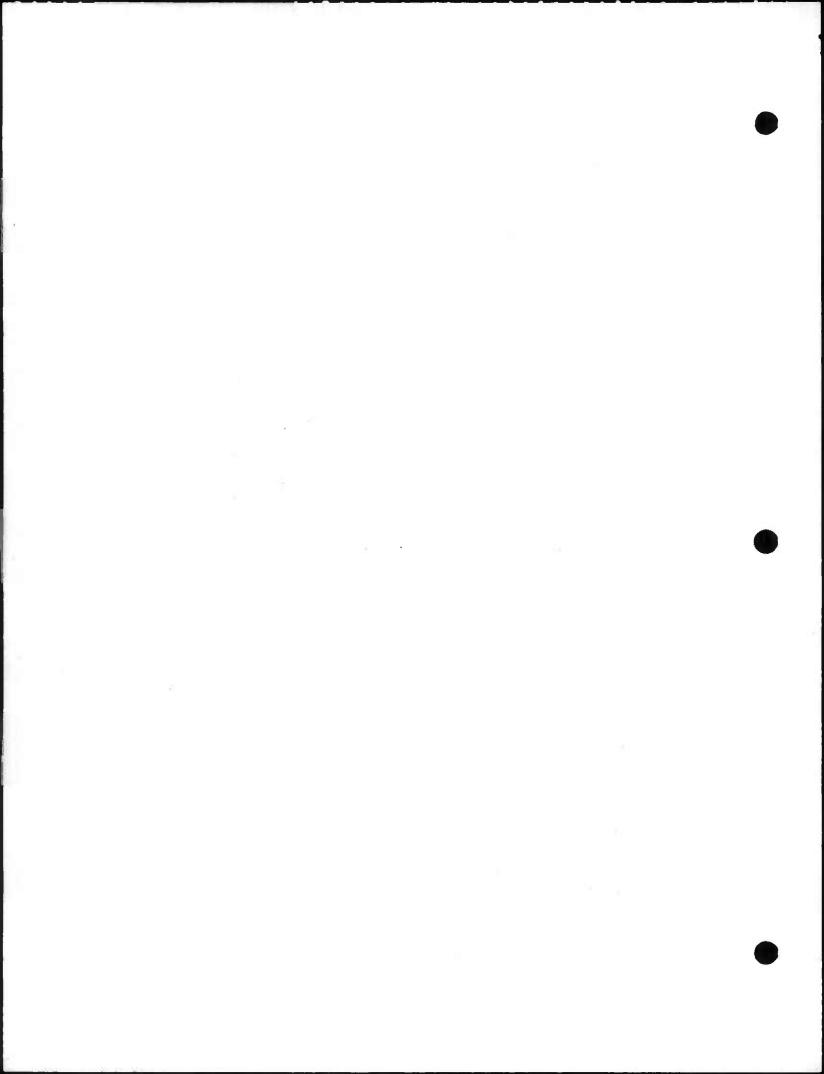
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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, I	design on a supplication designation of the same
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 12. 1994 David Kanzer Dec. 10:00 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 096-18-7009 1 X M 2 1 YRS. 20. Aug. 1907 New York Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Cherry Wood Manor Nursing Home DIRECTOR Reisterstown Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? within zernours after death. Page 6 may be retained by the hospital or attending physician, notetely filled in by the funeral director, page 5 should be detached for use as the burial-transit 6132 Allwood Court 21210 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, atc. If yes, specify Cuban, Maxican, Puarto RI
1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify 3 Wildowed 4 X Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY y/Secondary (0-12) College (1-4 or 5+) 8th Rigger Rigging Business once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Samuel Kanzer notified at BE Gussie Schliefer 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy Kanzer 6132 Allwood Court Baltimore, MD 21210 pe 20a. METHOD OF DISPOSITION
1 ☐ Burlai 2 🔼 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must Metro Crematory, Inc. 12/13/94 4 Donation 6 Other (Specify) Baltimore, MD the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAWN F . McDonald 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. CH oma 299 Frederick Rd. Baltimore, MD 21228 n and completely filled in by the to bunal, cremation, or removal. 23. PART i. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition 1A reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate physician cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events the attending p resuiting in death) LAST Injury, or PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 TYES 2 NO DF DEATH? 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IX UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA Nursing Home 5 - Rasidence 6 - Other (Specify) 6 27, MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is 6 Could not be COMPLETED PINEPAL DIRECTOR: determined Hem 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. = 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as attend. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D5-11 Dec. 13, 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Judah Minkove, M.D. 750 Main Street, Suite 205, Reisterstown, MD 21136 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Davidson Randall



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO. CERTIFICATE OF DEATH REG NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF OFATH MARGARET MONTH 2 VERONICA KELLY 2130 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH MONTHS DAYS HOURS 212-24-8132 1 M 2 TF 87 YRS JUNE 17,1907 MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 K YES 2 NO permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? burial-transit 428 S. AUGUSTA AVENUE 21229 U.S.A. urs after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2 X NO Specify: 1 Never Merried 2 Merried BY funeral director, page 5 should be detached for use as the 3 🔀 Widowed 4 🗌 Divorced WIHTE Ü 15. OECEOENT'S EDUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) LEI Elementary/Secondary (0-12) College (1-4 or 5 +) 8TH GRADE INSURANCE WRITER COMP COMMERCIAL CREDIT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROBERT FORRESTER N ELIZABETH KOESTERS BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. JAMES KELLY 435 CHALFONTE DRIVE - CATONSVILLE, MD 21228 e 200. METNDO OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 20s. METNDO OF DISPOSITION

1 CyBuriel 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) BALTIMORE NATIONAL CEMETERY12/14 BALTIMORE the medical examiner 21. SIGNATORE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. filled in by the foundary. the 4107 WILKENS AVENUE-BALTIMORE, 1.0.4.W 21229 23. PART i. Enter the diseases, or complications that ceused the daeth. Do not anter the mode of dying, such as cerdiec or respiratory arrest, Approximate ahock, or haert failure. List only one cause on each line. Interval Batween **IMMEDIATE CAUSE (Final** Onset and Daeth cremation, disease or condition_ completely resulting in death) 5 mon 15 or other traumatic event, executed with burial. CERTIFICATION . Greneralised and Sequantially list conditions, DUE TO (DR AS A CONSEQUENCE DF): prior to if any, leading to immediata cause. Enter UNDERLYING attending physician OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury O (DR AS A CONSEQUENCE O that initisted events resulting in death) LAST elomo Itable my the atter PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE NUTOPSY FINDINGS 24a, WAS AN AUTOPSY signed by the shows any COMPLETION OF CAUSE Health a 1 TES 2 NO OF DEATH? 1 TYES 2 NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) Hem r this certificate h OTHER: 1 YES 2 NO Inpatient 2 ER/Oulpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF OEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED marked, Natural 5 Pending м DIRECTOR: After the hours after death v BY 1 YES 2 NO Investigation Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 99 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Nomicide item 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. TO THE FUNERAL DE BE filed within 72 h (Check only one) MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end piece, and due to the cause(s) and menner as stated. 295, SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 불물 aracu ohn 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SIVASAILAM Baltimore 900 caton mo-Ave DEC 13 1994 32. REGISTRAR'S SIGNATURE i Danden-Ruddle

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
E E	TH et	IMPO	

	1 - STATE REGISTRAR	STATE OF MAR				HEALTH AND	D MENT	AL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					BEATT	2. DA1	E OF DEATH			3. TIME OF DEATH		
	NINA JEAN	KERR						PA 17	14	ALL H	4/0/A M		
	4. SOCIAL SECURITY NUMBER	5. SEX / 6. A	NGE (In yrs. las		F UNDER 1 YEAR		8. 7. DAT	E OF BIRTH		8. BIRTH Countr	IPLACE (State or Foreign		
	402 42 5933	1 🔀 M 2 🗆 F	60	YRS.	ONTHS DAY	HOURS MIN	100%	28/19	34	tucky			
	Se. FACILITY NAME (If not institution, give	street and number)		9	b. CITY, TOW	OR LOCATION OF	DEATH		EATH				
5	Stella Maris Hosp	pice		[Towson	1			Ba]	Ltimo	ore		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	~		140. 01994									
DIRECTOR		more County			OWN OR LO						10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	more country				e River			44. 017	1 YES 2 NO			
¥	1500 Becklow Av	enue				21220			iug. Ci i	WHAT COUNTRY?			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. AF	RMED	13. WAS D	ECENDENT OF HIS		IN? (Specify Yes	or No	U.S.A. No. 14. RACE — American Indian,			
	1 Never Married 2 Married	FORCES? 1 1	/ES 2 3	NO	If yes,	specify Cuban, Mea	ricen, Puert		0, 110-	Bleck	k, White, etc.		
B	3 Widowed 4 Divorced				1	ra z CXno apr	oury		Specify: White				
3	15. DECEDENT'S EDL (Specify only highest grade	CATION completed)	(G	CEDENT'S US	done durina	TION most of working	1	86. KIND OF BUS	SINESS/INC	DUSTRY			
او	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life	. Do NOT use n	etired.)								
COMPLETED	12		CI	erk -	Cashi	er		Groce	ery Store				
3	17. FATHER'S NAME (First, Middle, Last)						THER'S NAME (First, Middle, Malden Surname)						
H H		art					emma Bate						
2	190. INFORMANT'S NAME (Type/Print) Stewart Allen Keri		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, St										
		<u>c</u>	1500 Becklow Ave. Baltimore, Maryland 212										
1	20s. METHOD OF DISPOSITION 1 X Buriat 2 Cremation 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of came along) coupling place Date Continuo C												
1 Removal from State Camellon 3 Removal from State Camellon, corper place HOLLY HILL Mem. Gard.12/15/94 Balto. Co., Maryla 21. SignAture of Funeral Service Licensee 22. Name and address of Facility									aryland				
1	Q	() (BRUZI	DZINSKI	FUNEF	RAL HOM	E P.A	<i>.</i>			
	Jan 12	Sanh			1407	Eastern	Ave.	Balti	nore,	Md.	21221		
ı	23. PART I. Enter the diseases, or shock, or heart failure.	complications that car	used the de	eath. Do not	anter tha	noda of dying, a	uch aa ca	rdiac or reapi	ratory an	rest,	Approximate Interval Between		
											Onset and Death		
	disease or condition resulting in death)	. LUNG	-CA	NCE	R						6 mos.		
	DUE TO (OR AS A CONSEQUENCE OF):												
5	Sequentially list conditions, DIF TO (DR AS A CONSEQUENCE OF)												
HILLAHON	ous Enter UNDERLYING												
3	CAUSE (Disease or injury	cOUE TO (OR .	AS A CONSE	DITENCE OF									
	that initiated events resulting in death) LAST	552 15 (511)	A COMOL	OULINGE ON J.									
		d											
7	PART II. Other algnificant condition	ns contributing to dea	th but not i	resulting in t	the undarly	ing causa givan	In Part I.	24s. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDICAL PROPERTY OF THE PROPER								1 TYES 2			COMPLETION OF CAUSE OF DEATH?		
2									/ `		1 YES 2 NO		
	DID TOBACCO USE	CONTRIBUTE T	O CAU	SE OF	DEATH	YES X N	10 🗆						
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINERS	HOSPITAL:			THED.	PLACE OF DEATH							
ō	1 TYES 2 NO	1 Inpetient 2 ER/	Outpatient 3	DOA 4	☐ Nursing H	ome 5 🗆 Realden	ca 6X 01	her (Specify)	lospi	ce			
Ē	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJU (Month, Day, Ye		28b. TIME O		NJURY AT YORK?	28d. D	ESCRIBE HOW I	NJURY OC	CURED			
5	2 Accident Investigation					YES 2 NO							
3	3 Suicide 8 Could not be 4 Homicide determined										Route Number,		
. 1													
29e. CERTIFER (Check only only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. Description of the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. Description of the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated.													
) and menner as stated.				
	296. SIGNATURE AND TITLE OF CERTIFIE	ROO				29c. LICENSE	NUMBER		29d. DAT	E SIGNED	(Month, Day, Year)		
	Mendall	Klaw	Ku	elm	2	109	564	F3	▶ 1	2/1	0/94		
	30. NAME AND ADDRESS OF PERSON WI										1		
	DR. KENDALL FAULI			ANEY V	ALLEY	RD., T	OWSON	, MD 2	21204	·			
	31. DATE FILED (Month, Day, Year) DEC1 31994	32 REGISTRAR'S	GNATURE										
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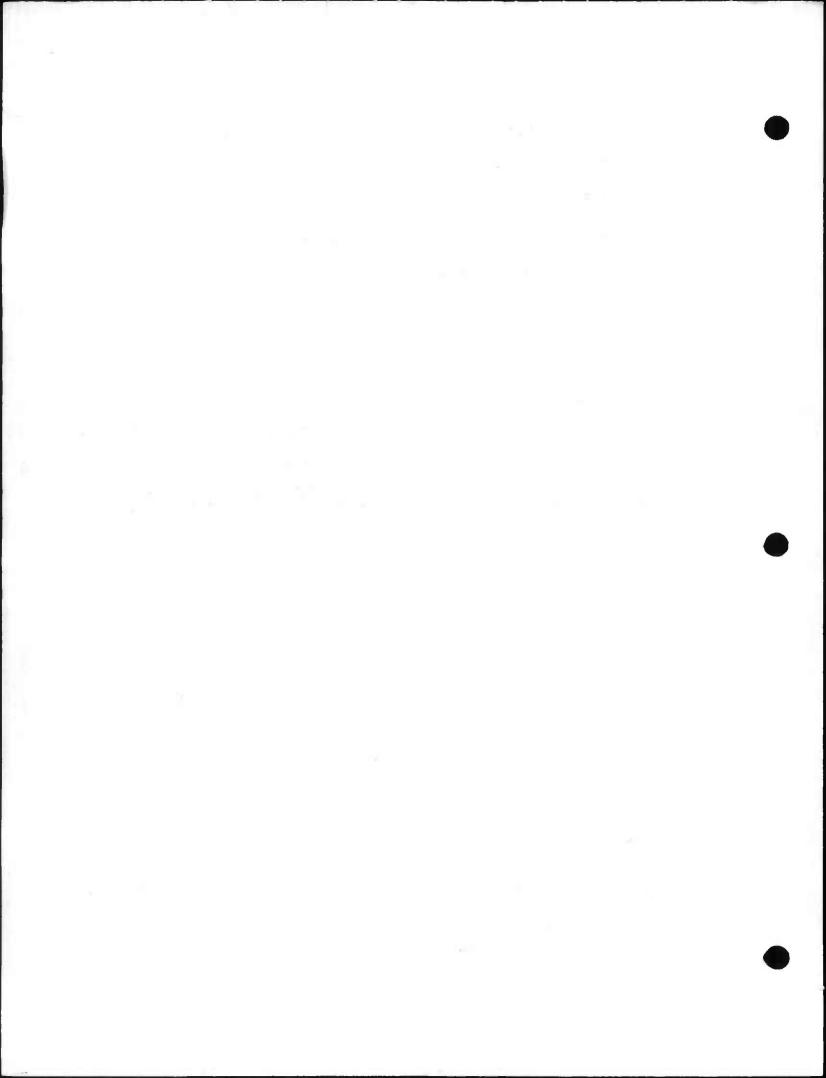
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DIVISION OF VITAL RECORDS, P.O. BOA 66/60	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
	TENDING
•	A
5	DR.
	SPITAL

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY HELEN н. KNATZ 12-11-94 1:15 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. A. BIRTHPLACE (State or Foreign 214-46-9784 1 M 2XXF 92 YRS 09-02-02 MARYLAND permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CARE - RUXTON DIRECTOR MANOR TOWSON BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE TOWSON 1 YES XX NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7001 NORTH CHARLES STREET 21204 U.S.A. the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XXNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Bleck, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR OATES В XXWidowed 4 Divorced WHITE use as t COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INOUSTRY jo College (1-4 or 5+) Figmentary/Secondary (0-12) HOUSEWIFE 12 YEARS OWN HOME detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) WILLIAM page 5 should be Ħ A. HARRIS HELEN STEINMAN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 **DOUGLAS** G. BOTTOM 2293 WYNDOM DRIVE, SPRING HILL, FL. 34606 pe 20a METHOD OF DISPOSITION
XXBurial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must funeral director, DRUID RIDGE CEMETERY 12-14 4 Donation 5 Other (Specify) PIKESVILLE, MD. 21208 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF HENRY W. JENKINS 8 SONS - Kutt 4905 YORK ROAD, BALTIMORE, MD. 21212 the or other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardisc or respiratory arrest, 3 Approximate 5 shock, or haart failure. List only one cause on each line Interval Between 20 filled IMMEDIATE CAUSE (Final Onset and Death and completely fille burial, cremation, disease or condition resulting in death) ena CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician ar Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST item 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS and AVAILABLE PRIOR TO signed | COMPLETION OF CAUSE 1 YES 2X 100 OF DEATH? 1 YES 2 NO been t. of I PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h HOSPITAL: HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA | X Nursing 1 TES XX NO e 5 Residence 6 Other (Specify) 10 28e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. with (XX Natural 5 Pending Investigation 1 YES 2 NO B After death 2 Accident 28s. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 90 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED DIRECTOR: hours after item 28 4 Homicide XXCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 MINIMPORTANT: If IN 2 MILDIAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner se stated. 29c. LICENSE NUMBER 29b. SIGNATURE, BE 29d. DATE SIGNED (Month, Day, Year) 12-12-94 2 WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) ANDERSON RENNICK M.D. 7600 OSLER DRIVE TOWSON, MD. 21204. 31. DATE FILED (Month, Day, Year) P. RESISTRARY OSIGNATURE 3 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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within 24 hours after death. Page 6 may b	funeral
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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND /	DEPARTM ERTIFICA	ENT OF	HEALTH AND	MENT	AL HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last) Margaret Kal	nn				Γ		mber m	8,19	94ª	3. TIME OF DEATH 9:00A
2		4. SOCIAL SECURITY NUMBER 579 54 9967	5. SEX 6. AGE (In			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH	1901	a. BIRTHP	LACE (State or Foreign
1, 2, 3 SHOUND	PLETED BY FUNERAL DIRECTOR	90. FACILITY NAME (If not institution, give str Hebrew Home of RESIDENCE OF DECEDENT		sh			OR LOCATION OF D				tgon	
II. rayes		10e. STATE 10b. COUNTY	tgomery		Silv		pring			-		10d. INSIDE CITY LIMITS? 1 YES 2 NO
		14514 Homecrest	· · · · · · · · · · · · · · · · · · ·				01. ZIP COOE		-			States
		11. MARITAL STATUS 1 Never Merried 2 Merried 2 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 — YES IF YES, GIVE WAR OR DAT	U.S. AR XIXIV ES	MED IO	If yes, a	CENDENT OF HISPA pectry Cubers, Mexico S 2 NO Specifi	en, Puerio		or No	Black,	- American Indian, White, etc. Casian
		15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Gi	CEDENT'S USU Ive kind of work Do NOT use ret Memake	done during ri ired.)	ION nost of working		Home	INESS/INC	DUSTRY	
at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) Bernard Spitz				18. MOTHER'S NA	AME (First,	Middle, Maiden	Surname)			
be notified	TO B	190. INFORMANT'S NAME (Type/Print) Harriet Rabin		5	805 M	idhi]	end Number or Rural 1. Stree	et	Bethe	sda,	Md.	20817
examiner must b		20e. METHOO OF DISPOSITION 120 Buriel 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify)	val from State K1	ng.	ND DATE OF DI	a Men	norial G	ard		Fall	s Ch	nurch, Va.
_{val.} ii examin		Manut	0			E	and Address of FA	urc	h, Vi	rgin	ia	22046
if, cremation, or removal event, the medical		IMMEDIATE CAUSE (Final	ongestive H	iea:	rt Fa:			th ss ca	rdiac or respi	ratory an	eat,	Approximata Interval Between Onset and Death Years
Mental Hygiene prior to burial, cremation, jury, or other traumatic event, the	CERTIFICATION	Due to (OR As A CONSEQUENCE OF): Hypertensive Cardiomyopathy Oue to (OR As A CONSEQUENCE OF): Hypertensive Cardiomyopathy Oue to (OR As A CONSEQUENCE OF): Essential Hypertension Years Years										
y, or other	CERTIF	that initiated events resulting in death) LAST										
th and	EDICAL	PART II. Other significant conditions	contributing to death but	t not r	eauiting in th	e undarlyl	ng causa givan in	Part i.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
23 Ppt	AN: M	DID TOBACCO USE CONTR		_				N 🗆				YES 2 NO
State	YSICI/		HOSPITAL: 1 □ Inpatient 2 □ ER/Outpat			HER:	me 5 🗆 Reeldence	8 🗆 Oth	er (Specify)			
death with the s marked, or	표	27, MANNER OF DEATH 1 Netural 5 Pending Investigation	28e. OATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	W	JURY AT ORK? YES 2 NO	28d. DE	ESCRIBE HOW IN	JURY OC	UREO	
affer deal	ETED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify	- Al ho	me, lerm, street	, fectory, off	се	281, LO City	CATION (Street at y or Town, State)	nd Number	or Rural Ro	ule Number,
22 hou	COMPLE	29e. CERTIFIER (Check only 2 CERTIFYING PHYSIC one) 2 MEDICAL EXAMINER	IAN: To the best of my knowled: On the best of exemination of									end menner ee stated.
be fled with	TO BE	200. SIGNATURE AND TITLE OF CHRISTIESER	typon	, ,	(n)		29c. LICENSE NUI D05885	MBER		29d. OAT	E SIGNED (F	8, 1994
,		Steven Lipson	6121 Mon	tr	ose Ro	d., F	Rockvill	е,	Md. 2	0852		
		DEC1 3 1994	STANGER TO AND	all,								

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uld be detached for use as the burial-transit permit, Pages 1, 2, 3 should led by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

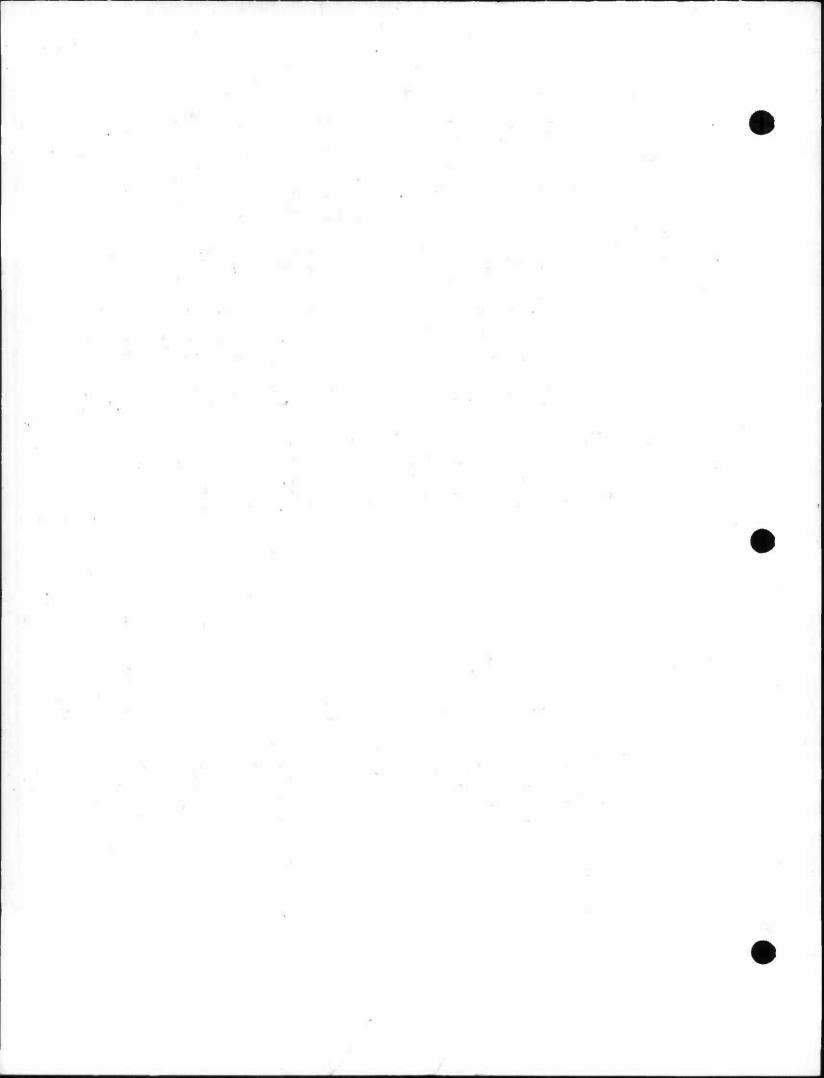
FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State heart, or Health and Mental Honline prior to having remarking or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICHE

	1 - STATE CERTIFICATE OF DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH		3. TIME OF DEATH		
	BERNARD JEROME KIMREY	11-24-94	YEAR	4:40A M		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTI	IPLACE (State or Foreign		
	241 18 4083 1 ☑ M 2 ☐ F 74 YRS. MONTHS DAYS HOURS MIN.	4-26-1920	No	Carolina		
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF D	e HTA	c. COUNTY OF D	EATH		
E C	12901 Pine Lane Beach Lusby		Calver	t County		
DIRECTOR	RESIDENCE OF DECEDENT					
뿐	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Calvert County	Lusby		10d. INSIDE CITY LIMITS?		
				1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 12901 Pine Lane, DrumPointBeach 20	657	0g. CITIZEN OF V USA	WHAT COUNTRY?		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPA 1 Never Married 14. WAS DECENDENT OF HISPA 15. WAS DECENDENT OF HISPA 16. WAS DECENDENT OF HISPA 17. YES 2 NO II yes, specify Cuban, Maxicu	NIC ORIGIN? (Specify Yes or	No- 14. RACI	E — American Indian, k, White, etc.		
ВУ	1 Never Married 2 Married FORCES7 1 X YES 2 NO It yes, specify Cuban, Maxici S YES, GIVE WAR OR DATES 1 YES 2 NO Specify Cuban, Maxici YES 2 NO Specify Cuban, Maxici YES 2 NO Specify Cuban, Maxici YES 2 NO Specify Cuban, Maxici YES 2 NO Yes, specify Cuban, Maxici YES 2 NO Yes, specify Cuban, Maxici Yes		Spec	White		
	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION	Lan anna an airein		WIIICE		
	(Specify only highest grade completed) (Give kind of work done during most of working	Real E		Broker		
2	Elementary/Secondary (0-12) 12+ College (1-4 or 5+) Music/Airline		ir For			
COMPLETED		ME (First, Middle, Maiden Sun				
		Estelle A		61		
BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural					
임	Mrs Mabel Kimrey 12901PineLane, Lus					
	20a. METHOO OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Agree of		TION — City or To	wn, State		
	1 Burlal 2 Cremation 3 Ramoval from Stata 4X Donation 5 Other (Specify)					
	21. SIGNATUME OF FUNE ALL SERVICE LICENSEF nald Wade, Dir 22. NAME AND ADDRESS OF FA	CILITYState AT	natomy	Board		
	owner 655W.Baltin	ore St, Bal	lto,MD	21201		
1	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, aud	h as cerdiec or respirate	ory erreet.	Approximate		
	shock, or heart fellure. Liet only one cause on each line. INMEDIATE CAUSE (Final	E 10 101 101 101 101	- Hoe	Interval Between Onset and Death		
		2184		40000		
	disease or condition resulting in deeth) a. Metastatic prostate Car DUE TO (OR AS A CONSEQUENCE OF):	1000		· gcar)		
z	C b					
티	Sequentially list conditions, If any, leading to immediate					
2	CAUSE (Disease or injury					
	thet initieted events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST			i i		
CERTIFICATION	d.					
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in			WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICAL		PERFORME		AWAILABLE PRIOR TO COMPLETION DF CAUSE		
ME				1 YES 2 NO		
ä				_		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (CI	eck only one)				
ĮS Į	HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidence	8 Other (Specify)				
H	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK?	28d. DESCRIBE HOW INJU	JRY OCCURED			
BY	1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO					
COMPLETED	4 Homicide determined					
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due	to the cause(s) and manner	r an stated.			
OM	one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the	time, data and place, and d	us to the cause(s	s) and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NU	WBER 25	9d. DATE SIGNED	(Month, Day, Year)		
BE	Charles W. Bennett M.D. 125	156	12/2	194		
٩	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		-			
	DR CHARLES BENNETT POBox 550, Lusby, MD 2	0657				
	31. DATE FUE C 13 1994 Silver Daniel Strike State of the State of the state of the					
	DE 19 1994 (V)					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

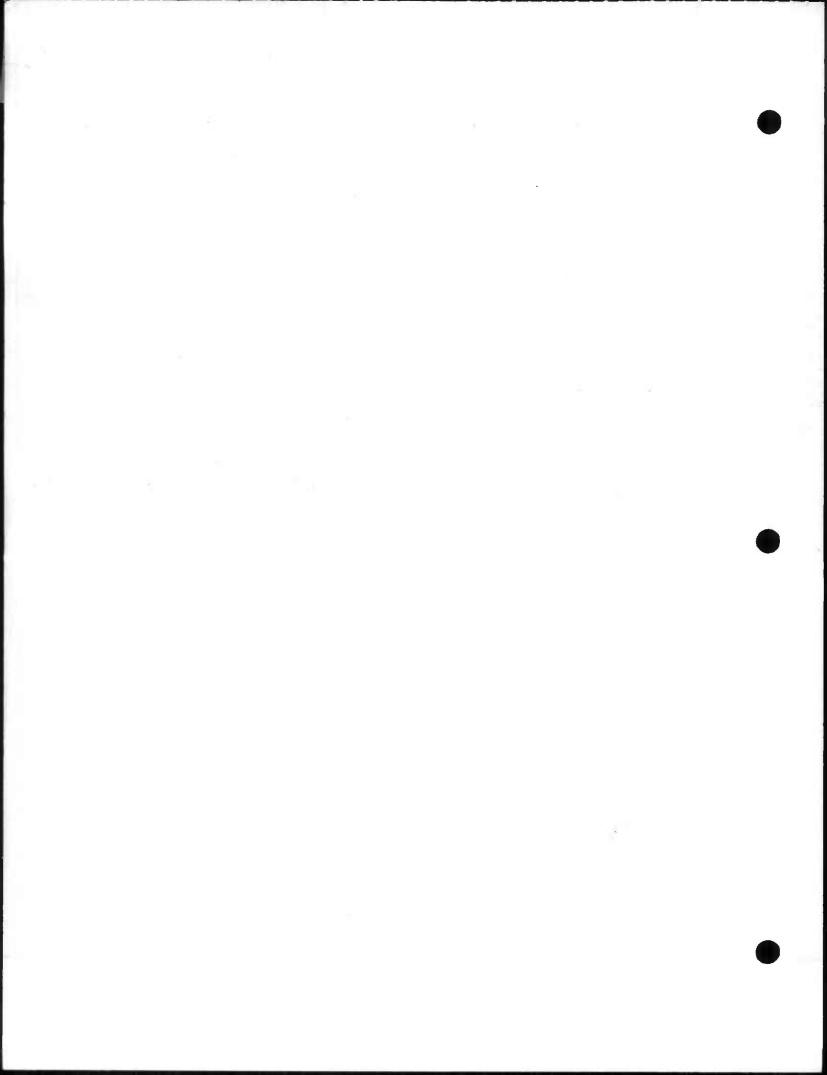
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MAR		ENT OF HEALTH AND N	MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) RICHARD	THOMAS	LOWE		2. DATE OF DEATH DATE CEMBER	" 11,ĬŌ9	3. TIME OF DEATH	
		1 📈 XM 2 □ F	84 YRS. MONT		JAN. 29, 191	8. BIRTH Countr VIR	PLACE (State or Foreign	
TOR	90. FACILITY NAME (II not institution, give stre 1004 N. RESIDENCE OF DECEDENT		STREET 96. (BALTIMORE	CITY	9c. COUNTY OF D	EATH	
DIRECTOR	10e. STATE 10b. COUNTY	n/a	10c. CITY, TOV	VN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1) YES 2 NO	
FUNERAL	100. STREET AND NUMBER 1004 N.	WOLFE ST	REET	101. ZIP CODE 21205		10g. CITIZEN OF V		
В	11. MARITAL STATUS 1 Never Married 2 Married 3 XXVIdowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR C		13. WAS DECENDENT OF HISPANI If yes, specify Cuben, Mexicen 1 YES 2 NO Specify:	, Puerlo Ricen, etc.)		- American Indian, , white, etc.	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) 8 TH		18a. DECEDENT'S USUA (Give kind of work of life. Do NOT use retin LABORER	one during most of working ed.)		HEM STEE	_ YARD	
BE CO	17. FATHER'S NAME (First, Middle, Last) ROBERT LOWE			18. MOTHER'S NAM CHANII	AE (First, Middle, Maiden E BRANCH	Surneme)		
10	190. INFORMANT'S NAME (Typo/Print) LOUISE LONG		196. MAILING ADDR 5676	MORTON STREE	T, BALTIMO	RE, MARY	LAND 21	
	20e. METHOD OF DISPOSITION XIX Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DIS COMPLETY COMPLETE OF DISCOURSE TO SERVICE OF THE PROPERTY OF THE PR			TIMORE,		
	21. SIGNATURE OF FUNERAL SERVICE LICE AU V. 3			WM. C. MARCH		E. NORTH	AVENE.	
	23. PART I. Entar the diseases, or co ahock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	ist only one cause o	en each lina.	nter the mode of dying, auch		ratory arrest,	Approximete interval Batween Onset and Death	
Sequantielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								
PART II. Other algnificent conditions contributing to death but not-resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? 1 Inpetion 2 ER/Outpatient 3 DOA OTHER: 1 Inpetion 2 ER/Outpatient 3 DOA OTHER: 1 Number OF DEATH 28b. DATE OF INJURY (Month, Day, Year) 25. WAS CASE REFERRED TO MEDICAL 28b. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28b. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28b. INJURY AT 28d. DESCRIBE HOW INJURY OCCI.						MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ICIAN		HOSPITAL:	28. PLACE OF DEATH (Ch	eck only one)				
The state of the s						JURY OCCURED		
ED BY	1) Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide 8 Could not be determined 1 Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Pound Natural Natural Science Natural Pound Natural Natural Science Natural Nat							
COMPLETED				he time, date end place, end due t			end manner as stated	
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNE 1						29d. DATE SIGNED	100	
TO	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AN ANCIONAL OF 1830 E, MONUMENT ST EM 9026 31. MYE FIRST (MOTIFIC ON 1977) AN ENERGY (MOTIFIC ON 1977) AN ENERGY (MOTIFIC ON 1977) AN ENERGY (MOTIFIC ON 1977) AN ENERGY (MOTIFIC ON 1977) AND AND AND AND AND AND AND AND AND AND							

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fter death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR And this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours are with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 2 is netted, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PLYSICIAN: MEDICAL CERTIFICATION

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
1	ALBERT A	A. LAMBI	ERT, SR			DECEMBER "	12,1994	1:45 P M
	4. SOCIAL SECURITY NUMBER 5. S	SEX 6. AGE (In	yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign
	216-07-1704 15	M 2 D F 8	8 YRS.	1/4	R LOCATION OF DE	OCTOBER 26,		ryland
OR	NORTH ARUNDEL HOSPI			GLEN E		, and the		COUNTY
EG	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
DIRECTOR	Md. Anne	Arundel	Glen	Burnie	200			1 TES 2X NO
IAL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	7885 Gordon Ct.				21061		USA	
5	1 Never Married 2 Merried	WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, spe	city Cuben, Maxice	HC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	or No— 14, RAC Bla	CE — Americen Indian, ck, White, etc.
BY	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	res"	1 TYES	2 NO Specify	r:	Spe	white
8	15. DECEDENT'S EDUCATION (Specify only highest grade company)	ON	16e. DECEDENT'S U			16b. KIND OF BUS	SINESS/INDUSTRY	
		ollege (1-4 or 5 +)	life. Do NOT use	all"	st of working			
COMPLETED	12		Boiler	Maker			hem Stee	1
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Surneme)	
BE	Augustus Lambert 190. INFORMANT'S NAME (Type/Print)				Clara			
2	Margaret E. Zaiser	,				Route Number, City or Town		210/2
	200. METHOD OF DISPOSITION	T T	PLACE AND DATE OF				CATION — City or 1	
	1 Burial 2 Cremetion 3 Hamoval 4 Donation 5 Other (Specify)	from State ceme	tery, crematory or other	er place)		12/ ₁₃ Bal		
	21. SIGNATURE OF EUNERAL SERVICE LICENS		ie izreeu	22. NAME AN	D ADDRESS OF FA	CILITY		
	· Lay 2.	toufor	renz			n Funeral <u>Flkridae</u>		Elk., Inc.
	23. PART I. Entar tha diseases, or companies, or heart fallura. List	plications that caused	tha death. Do no	t anter tha mo	da of dylng, suc	h as cardiac or reapl	refory arrest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final	only one cause on an	on mie.					Onsat and Desth
1	resulting in death)	DUE TO (OR AS A	mon	4 6	my 11	ST		
_								
CERTIFICATION	Sequantially list conditions, if sny, leading to immediata	DUE TO (OR AS A	CONSEQUENCE OF)	- / ·×				
S	cause. Enter UNDERLYING CAUSE (Disease or Injury							
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
EH I	d			_				
4	PART II. Other significant conditions co	ontributing to death bu	t not reaulting in	the undarlying	cause given in	Part I. 24a. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
S						1 YES 2		COMPLETION DF CAUSE OF DEATH?
ME								1 TYES 2 NO
Ä	DID TOBACCO USE CONTRIB				UNCERTAIN	1 🗆		
YSICIAN: MEDIC	EXAMINER?	OSPITAL:		OTHER:				
٤	27. MANNER OF DEATH	Inpatient 2 ER/Outpe	28b. TIME	OF 28c. INJ	URY AT	6 Other (Specify) 26d. DESCRIBE HOW II	NJURY OCCURED	
¥ 61	1 Netural 5 Pending	(Month, Day, Year)	INJU		RK? 'ES 2 NO .			
2 Accident Investigation 3 Suicide & Could get be 26e. PLACE OF INJURY — At home, ferm, etreet, tectory, office 26f. LOCATION (Street and Number or Rural Rout							Route Number,	
#1	4 Homicide detarmined		,,			City or Town, State)		
COMPLET	Control only	: To the best of my knowle	dga, death occurred	at the time, data	end place, end due	to the cause(e) and man	nner as stated.	
NO.	2 MEDICAL EXAMINER: O	n the beele of examination	and/or investigation.	, in my opinion, de	eath occured at the	time, date and place, en	d dua to the ceuse	(e) end menner as stated.
BE	29 SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	MBER	29d. DATE SIGNE	D (Month, Day, Year)
TO E	MMX				1127	838	12/	294
	JOHN SHAVERS, M.				ITHICHM	MD 21090		/
		32 REGISTRAR'S AGNA		L ND/LI	THEOUP,	mu 21030		
	DEC1 3 1994 July	dimension have	Tall					



I or attending physician. or use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	CO DE COMBIETER DE DESCRIPTION MENORMAN DE COMPANION DE C
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 more than the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
e funeral director, page 5 should be detached to	TO THE FUNERAL DIRECTION After this grant cate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for
r death. Page 6 may be retained by the hospital	TO THE HOSPITAL OR AT MINDLE PRISHOAN: The law requires that the death certificate be executed within clours after death. Page 6 may be retained by the hospital

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)			-		2. DATE OF DEATH		3. TIME OF DEATH	
	Donald James	s Lange				December		YEAR	
	250 34 5055	5. SEX 6. AGE (In yrs	s. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	44 - 4 - 5 - 14 - 1			BIRTHPLACE (State or Foreign Country) Illinois	
	9a. FACILITY NAME (If not institution, give stree			9b. CITY, TOWN C	OR LOCATION OF DE			TY OF DEATH	
E I	Mercy Hospital			Balti		Jan Co		T OF DEATH	
5	RESIDENCE OF DECEDENT								
DIRECTOR	Maryland 10b. county			, town or Locat Baltimor				10d. INSIDE CITY LIMITS? 1 📉 YES 2 🗌 NO	
FUNERAL	100. STREET AND NUMBER 103 W. Monumen	nt Street			ZIP CODE			EN OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 Ves 2 IF YES, GIVE WAR OR DATES 1955-	DNO	If yes, spe		HC ORIGIN? (Specify n, Puerlo Rican, etc.)	Yea or No- 14	4. RACE — American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondary (0-12)	TION 18a	Give kind of wo	JSUAL OCCUPATION of done during most retired.)	on st of working entative		PUSINESS/INDUS		
M		3	Sares	Kehrese			ustrial	-	
BE CO	17. FATHER'S NAME (First, Middle, Lest) Herbert C.	Lange			18. MOTHER'S NAI	ME (First, Middle, Meid Lan Vyzr			
10	19a. INFORMANT'S NAME (Type/Print) Marybeth Lange			ADDRESS (Street at	nd Number or Rural F	Route Number, City or 1	own, State, Zip C	ode)	
	20e METHOD OF DISPOSITION 20 Burlet 2 Cremetion 3 Remove	20b. PLA	CE AND DATE OF	F DISPOSITION (Na	me of	DATE 20c.	LOCATION — CI	ty or Town, State	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN		ney var	22 NAME AN	ID ADDRESS OF EA	OH ITY			
	Market .	D.S.	9	Ruck T	lowson Fu	ineral Hon I, Towson			
	23. PART I. Enter the diseases, or cor ahock, or heert failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplicationa that caused the et only one cause on each	line.		de of dying, such	h aa cerdlac or red	piratory arrea	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST								
	BART II Other significant conditions		S						
PHYSICIAN: MEDICAL	PART II. Other algolificant conditions of	contributing to death but in	ot resulting in	the underlying	j ceuse given in		ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ž	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF D	EATH YES		UNCERTAIN			1 1 150 5 1 140	
N N	25. WAS CASE REFERRED TO MEDICAL	26. P	PLACE OF DEATH	(Check only one)					
l Si		HOSPITAL:		OTHER: 4 Nursing Home	5 Rasidenca	8 Other (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WOI	NJURY AT YORK? 28d. DESCRIBE HOW INJURY OCCURED				
TED BY	2 Accident investigation 3 Suicide 8 Could not be determined	t home, farm, str	Ime, farm, street, factory, offica 28f. LOCATION (Street and Number or Rural Route Numb City or Town, State)			Rural Route Number,			
COMPLET		AN: To the best of my knowledge On the basis of examination and							
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	P. Con	16/	40	29c, LICENSE NUM	BER 3			
-	30. NAME AND ADDRESS OF PERSON WHO C	d Costlow M.			ve. Tim	onium. Ma	rvland	21093	
1	31. DATE ELEC 10073 7994 July	AC MEDICATION A SHELLY HOL	i.		,				

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 11:59 A. Roland L. LeBrun December A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 065-10-6237 (Month, Day, Year) 10-3-1909 HOURS MIN. 1 😡 M 2 🗌 F YRS. Massachusetts Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATN Greater Baltimore Medical Center DIRECTOR Towson Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 XYES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? rours after death. Page 6 may be retained by the hospital or attending physician. If in by the funeral director, page 5 should be detached for use as the burial-transit 200 Cross Keys Road, Unit 63 21210 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 HO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indien, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR OATES White В Specify: 3 Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ᆸ Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) Salesman COMPL Greenspan 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) to Leopold M. LeBrun Alice Gagnone BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Charles H. Wineholt 6863 Batiquitos Drive, Carilbad, Calif. 92009 pe 20e. METNOD OF DISPOSITION
1 ☐ Burlel 2X Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - Cify or Town, State must Hilltop Service Corp 12- 13-94 4 Donation 5 Other (Specify) Towson, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 7 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, completely filled in by the ahock, or haart failure. List only one cause on each line. interval Between 0 IMMEDIATE CAUSE (Final **Onset and Death** the cremation, disease or condition Longestive Heart Failure wech event, resulting in death) OUE TO (OR AS A CONSEQUENCE OF): executed bunal, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to if any, leading to immediate the attending physician I Mental Hygiene prior to that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part 1. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS een signed by the AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? Digoxin toxicity shows any Mitral Insuffice 1 YES 2 TONO Stroke 1 TES 2 NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 TENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) eer this certificate ha item 26. PLACE OF DE HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNEB OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO ater tegh 28 is mg BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 🔲 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. FUNERAL (
within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner es stated. TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d, DATE SIGNED (Month Day Year) BE Miloney MD 142129 12-9-94 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

William McConnell, M.D.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

500 W. University Parkway, Baltimore, Md. 21210

NOF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 3 PHYSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 may be retained by the hospital or attending physician. If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bund-transit permit. Pages 1, 2, 3 shi with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	edical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	21 PES 10e. S Mai 10e. S 21 11. MA 1
DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-train be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequilif any causing CAUS that it result PART DIII 25. WA EX 1 [27. MA 296. C(C) 296. Si 30. NAI 30. NAI

31. DATE FILED (Month, Day, Year)

DEC 13 1994

32. REGISTRAR'S SIGNATURE

	11em2UD 12-13-94 F1.	IIIIG/10 W.	n.Per	r/n							91	i J	0 143
	1 - FOR STATE REGISTRAR	STATE OF MA					IEALTH DEAT			HYGIENE REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)	Palmer	r Josep	h Lar	mar.	Sr.			2. DATE OF MONTH	DAY		YEAR	3. TIME OF DEATN
ò	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. les			R 1 YEAR	IF UNDER	24 HDC	Dece	mber	11,1		7:00 AM M
	The state of the s	1 X M 2 - F	91	YRS.	MONTHS		HOURS	MIN.	(Month, D	L/190	٦	Country	
	9e. FACILITY NAME (If not institution, give street	et and number)			9b. CIT	Y, TOWN (OR LOCATIO	ON OF DE		1/1/0		NTY OF DE	4
OR	2147 Willow Green	Road No	rth			Esse	X				B	altin	ore
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY			10c. CIT	Y. TOWN	OR LOCAT	ION						10d. INSIDE CITY
DIR	Maryland	Baltimo	re		.,		5500	Ess	ex				LIMITS?
	10s. STREET AND NUMBER					10/	. ZIP CODE		<u> </u>		10g. CITI		HAT COUNTRY?
FUNERAL	2147 Willow Green	Road No	orth					21	221		Ui	nited	States
5	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT I	EVER IN U.S. AR	IMED	13.				IIC ORIGIN? (:		or No-	14. RACE Black,	- American Indien, White, etc.
В	3 Widowed 4 Divorced	IF YES, GIVE WAF					2 NO			,,		Specify	
	15. DECEDENT'S EDUCA	TION		CEDENT'S					16b. KI	ND OF BUS	INESS/INC	USTRY	WILLCE
Ш	(Specify only highest grade co	College (1-4 or 5+)	(G.	ive kind of v Do NOT us	work done sa ratired.)	during mo	st of working	g					
COMPLETED	8 Years		Br	ick 1	Laye	r			St	eel :	Indu	stry	
	17. FATNER'S NAME (First, Middle, Last)								ME (First, Mide				
BE	George Lamar 190. INFORMANT'S NAME (Type/Print)		10	h MAII INC	ADDRES	O (Street o		Mati	lda Route Number,	(Not			
임	Palmer J. Lamar,	Jr.	191						sex, 1	,		2122	11
	20a, METHOD OF DISPOSITION		20b. PLACE	ANDRATE	OF DISPO	SITION (Na		التراث الم	DATE	_		City or Tow	
Į	1 Burlel 2-X Cremetion 3 Remove 4 Donetion 5 Other (Specify)	al from State	Hills	ton	ther place	1		12/	13/94	1			vland
	21. SIGNATURE OF HUNERAL BERVICE LICES	MEE /		-	22.	. NAME AN	ID ADDRES	S OF FAC	CILITY				
	I (that IN.	Took											alk, Inc. and 21222
	23. PART I. Enter the dieseses, pr cor ahock, pr heart fellurs. Lie	mplications that o	ceused the de	ath. Do r	not ente	r the mo	de of dyli	ng, such	h ss cerdie	or reepir	alory sm	rest,	Approximete
	IMMEDIATE CAUSE (Finel	- 1 mm - 2 - 5 mm / 1980				+	0						Interval Between Onset and Death
	disesse or condition resulting in desth)		C/CN OR AS A CONSEC	wy	all	M, C	TID	ea.	re				
_		DUE TO (O	R AS A CONSEC	DUENCE OF	F):								
o No	Sequentially liet conditions, if any, leading to immediate	DUE TO (O	R AS A CONSEC	DUENCE OF	P):	_							
S	cause. Entar UNDERLYING CAUSE (Disease or Injury												
ERTIFICATION	that initiated events	DUE TO (O	R AS A CONSEC	DUENCE OF	F):								
CER	resulting in deeth) LAST												
_	PART II. Other significent conditions	contributing to de	eath but not r	resulting i	in the u	nderlying	ceuse g	iven in	Part I. 24	e. WAS AN			WERE AUTOPSY FINDINGS
MEDICA									1	PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	OF DEATH? 1												
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
ᅙ	EXAMINER?	TOSETIAL. OTHER:											
PHYSICIAN:	27. MANNER OF DEATN	1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
	Natural 5 Pending	(Month, Day, Year) INJURY WORK?											
D 84	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY — At home, term, street, fectory, office 26f. LOCATION (Street and Number or Rural Route Number						oute Number,					
ELE	4 Nomicide determined	building, etc	a. (Specify)						City or 1	own, Stete)			
MPLE	29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAL	AN: To the best of my	y knowledge, de	ath occurr	ed at the	time, date	end piece,	end due	to the ceuse(e) end menr	ver es stat	ed.	
O 11	one) 2 MEDICAL EXAMINER:	On the beele of exam	nination end/or i	Investigatio	n, In my	opinion, d	eath occure	d at the t	time, date en	d place, end	due to th	e ceuse(e)	end manner ee stated.
BEC	296. SIGNATURE AND TITLE OF CERTIFIER	/					29c, LICE	NSE NUM	IBER		29d. DATI	E SIGNED	(Month, Day, Year)
0	30, NAME AND ADDRESS OF PERSON WHO	11					DI	85	18		> /	2/11	195

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O. BOX	certificate
7.	death
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MECONDS	requires
1	W.
4	The
OF VIIAL	PHYSICIAN:
DIVISION OF	OR ATTENDING PHYSICIAN: The law requires that the death certificate
5	BB

31. DATE FILED (Morith, Day, Year)
DEC1 3 1994

one area usable o may be retained by the hospital of attenuing prosecular.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	yoval.	cal examiner must be notified at once.
CIE	led in by	I, or rem	medic
THE OR ALLENDING PHYSICIAN. The Idw requires that the beautifule be executed within	NETAL DIRECTOR: After this certificate has been signed by the attending physician and completely fills	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation,	MAT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifi
3	5	27	ಡ

	1 - FOR STATE REGISTRAR	STATE OF N	/ MARYLAND CI	DEPAR					MENTA	REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)		Lombardi					of DEATH	1994	1 YEAR	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER	5. SEX	holas	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign		
	216-05-0920	1 T/M 2 - F	83	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	n, Day. Year)	11	Countr			
	9a. FACILITY NAME (If not institution, give si	reet and number)			9b. CITY	, TOWN C	R LOCATIO	ON OF DE		,	_	INTY OF D			
R	Stella Maris H	Jospice				Dulaney Valley Balto.Co.							.Co.Md.		
DIRECTOR	RESIDENCE OF DECEDENT										· co · na ·				
HE	Cardina Company					TY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?		
	Maryland		-	B	alto								1 🔀 YES 2 🗌 NO		
FUNERAL	10e. STREET AND NUMBER					101	ZIP CODE						ZEN OF WHAT COUNTRY?		
		Villiam				21230 United									
5	11, MARITAL STATUS 1 Never Married 2 Merriad	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF							1? (Specify Yea Ricen, atc.)	or No-	14. RACE Black	E — American Indian, c, Whita, atc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE V	AR OR DATESX	(1	1 TYES 2 TNO Specify:						Speci	w White		
o i	15, DECEDENT'S EDU	CATION	16a, DE	ECEDENT'S	USUAL O	CCUPATIO)N		168	. KIND OF BUS	SINESS/IN	OUSTRY			
COMPLETE	(Specify only highest grade Elementary/Secondary (0-12)		(C	ive kind of a	work done i	during mo-	st of workin	g	1						
7	12th.Grade -	Consign (1-4 or 5	' I	cour	- C1	orlo			- 1	D - 1	+0	City			
N O	17. FATHER'S NAME (First, Middle, Last)			Juli	<u>. (.)</u>	EIK		HER'S NA	ME (First,	Middle, Maiden		4114	/		
	Carlo	- Lo	mbardi				E	ufra	asin	a	_	Di	idiacomo		
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	\$ (Street a		Number or Rural Route Number, City or Town, State, Zip Code)							
2	Mrs, Patricia	A.Cvsvk	.	90 1	E.Pa	നവര	ia 1	Rd.	Apt.	103 7	'i mo	nium	n.Md.21093		
	20g, METHOD OF DISPOSITION		20b. PLACE	OF DISPO					100			- City or To			
	1 X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State	other p	_{laca)} v Re	deer	mer	Cem	+	12/	′1 4/ Ba	lto	.Cit	cy.Md.		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE					D ADDRE		CILITY		1	Ra 1 t	o.Md. 2123		
	1	11.0.14				McC	11111	v F	unei	ral Ho			E.Fort A		
	23. PART I. Enter the diseases, or	complications the	t caused the di	eath Do	not enter			_					Approximate		
	shock, or heart failure.											,	intarval Between Onset and Death		
	IMMEDIATE CAUSE (Finel disease or condition								Oliset slid Destil						
	resulting in death)	a. OUE TO	OUE TO (OR AS A CONSEQUENCE OF):										-		
_		Ross	0	4											
RTIFICATION	Sequentielly list conditione, if eny, leading to immediate	F):	:												
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury														
Ĭ.	that initiated events		(OR AS A CONSE	QUENCE O	F):										
ERI	resulting in death) LAST	d													
O	PART ii. Other significent condition	e contributing to	death but not	resulting	in the ur	nderivin	CRIISA (given in	Part i	24s. WAS AN	ALITOPSY	246	. WERE AUTOPSY FINDINGS		
₹ S		H sen		_	in the onderlying cause given in					PERFOR	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
	40-19700	. (= 0=								1 YES 2	NAO		OF DEATH?		
									_				1 TYES 2 NO		
2						26 DI	ACE OF O	EATH /Ch	andr only o	200					
AN: M	25 WAS CASE REFERRED TO MEDICAL			EXAMINER? / HOSPITAL: OTMER:											
ICIAN: MI			T EDIO de alla est			1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)									
HYSICIAN: MI		1 Inpatient 2			4 Nut	rsing Horr		naldenca			NJURY O	CCUREO			
	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Natural 5 Pending	1 Inpatient 2	INJURY	28b. TIR	4 Nut	28c. INJ WC					NJURY O	CCUREO			
BY PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Natural 5 Pending investigation	1 Inpatient 2 [28a. OATE Of (Month, I) 28a. PLACE O	FINJURY Day, Year) OF INJURY — At h	28b. TIR	4 Nur NE OF JURY M	28c. INJ WC	URY AT PRK7 YES 2		28d. DE	SCRIBE HOW I	and Numb		Route Number,		
BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Natural 5 Pending	1 Inpatient 2 [28a. OATE Of (Month, I) 28a. PLACE O	F INJURY Day, Yoar)	28b. TIR	4 Nur NE OF JURY M	28c. INJ WC	URY AT PRK7 YES 2		28d. DE	SCRIBE HOW I	and Numb		Route Number,		
BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH T Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide 6 Could not be	1 □ Inpatient 2 □ 28a. OATE OI (Month, L) 28a. PLACE (building	FINJURY by, Year) OF INJURY — At h, atc. (Specify)	28b. TIN IN oma, ferm,	AE OF JURY M atreet, fec	28e, INJ WC 1 -	URY AT PRK7 YES 2	□ NO	28d. DE	SCRIBE HOW I CATION (Street or Town, State)	and Numb	er or Rural i	Route Number,		
BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH T Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Chock only	1 Inpatient 2 [28a. OATE Of (Month, I) 28a. PLACE (building)	FINJURY ay, Yoar) OF INJURY — At h atc. (Specify)	28b. Tin	AE OF JURY M atreet, fec	28c. INJ WC 1 ctory, office	URY AT PRK7 YES 2 [NO	281. LOC	SCRIBE HOW I	and Numb	er or Rural i			
	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH T Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Chock only	1 inpatient 2 [28a. OATE Of (Month, I) 28a. PLACE Of building ICIAN: To the best of I	FINJURY ay, Yoar) OF INJURY — At h atc. (Specify)	28b. Tin	AE OF JURY M atreet, fec	28c. INJ WC 1 ctory, office	URY AT PRICE 2 a and place laath occur	NO	28d. DE 28f. LOC C/t) a to the ca	SCRIBE HOW I	and Numb	er or Rural I	Flourite Number, a) and manner as stated. (Manth, Day, Year)		

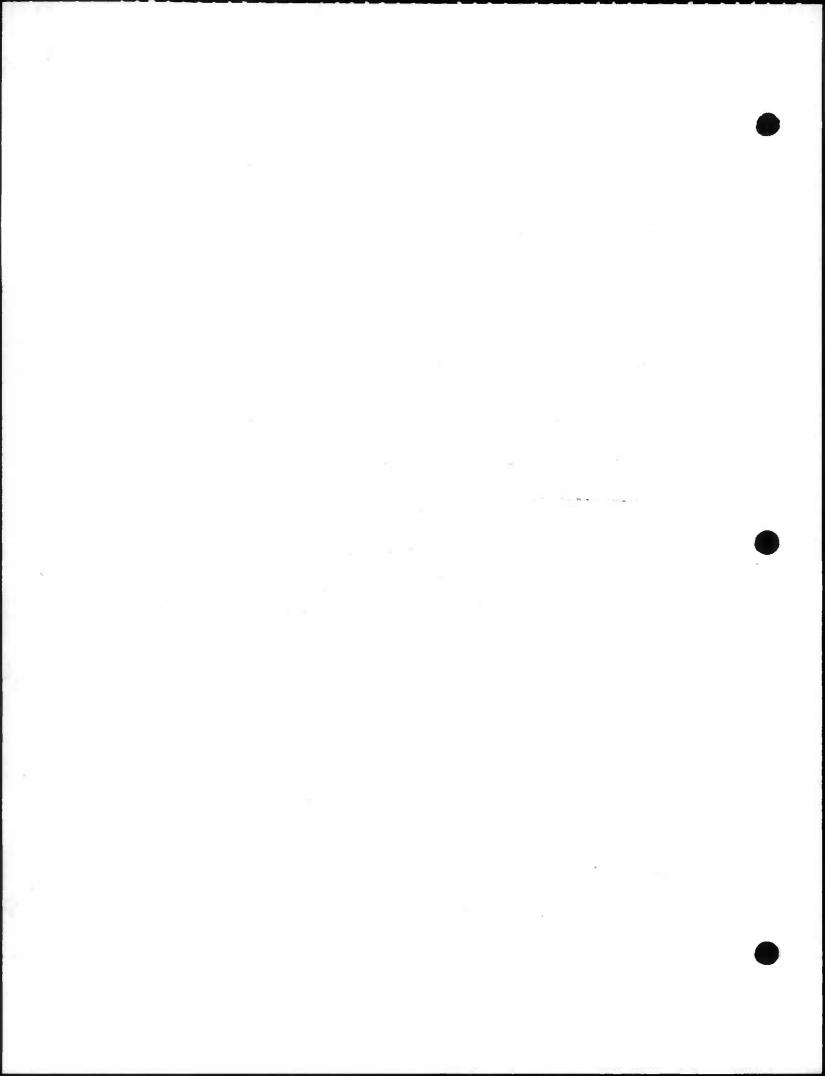
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF MARY	OF HEALTH AND MENTAL HYGIENE OF DEATH REG. NO.								
ŀ	1. DECEDENT'S NAME (First, Middle, Last) Robert Allen Lambert	2. DATE OF DEATH DEC. 11, 1994 3. TIME OF DEATH								
	4. SOCIAL SECURITY NUMBER 184-285-159 1X M 2 F 5. SEX 6. AGE (in yrs. lest birthday) F UNDER 1 1 MONTHS C	YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS MIN. Sept. 30, 1936 Maryland 8. BIRTHPLACE (State or Foreign County) Maryland								
OR	13 Tucker Street 21	OWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH USA								
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY MD Anne Arundel Annapol	Tool motor off								
FUNERAL	10. STREET AND NUMBER 13 Tucker Street	101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21401 USA								
BY FUNE	11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married FORCES? 1 ☐ YES 2 ☑ NO If y	IS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, White Specify: White								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16e. DECEDENT'S USUAL OCC (Give kind of work done dur	ring most of working								
MP	12 5+ History Pro									
	George Lambert	18. MOTHER'S NAME (First, Middle, Meiden Surmame) Doris Nehring								
BE		Street and Number or Rural Route Number, City or Town, State, Zip Code)								
5		Street, Annapolis, MD 21401								
	20a. METHOD OF DISPOSITION 1	ON (Name of DATE 20c. LOCATION — City or Town, State								
		me and address of facility rdesty Funeral Home, P.A.								
	Momps 1/ Halleron 12	Ridgely Ave. Annapolis, MD 21401								
	23. PART 1. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate Interval Batween Onest arid Death									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate course. Enter UNDERLYING CAUSE (Disease or injury that initiated avanta reaulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
AL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 248. WAS AN AUTOPSY PERFORMEO? 1 YES 2 INO 240. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	O X UNCERTAIN								
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpellant 2 ER/Outpetient 3 DOA 4 Nursing	y one) g Homa 5 € Residence 8 □ Other (Specify)								
ву РНУ	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY	BC. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED WORK? 1 YES 2 NO								
	3 Suicide 6 Could not be determined 26a. PLACE OF INJURY — At home, farm, street, factory building, stc. (Specify)	7, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
TO BE C	296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE NUMBER D21438 296. OATE SIGNED (North, Day, Year)									
-		y Ave. #120, Annapolis, MD 21401								
	DECT 3 1994 July Dawator Randell									



1:00

> Approximete interval Between Onset and Death Z Dans

2. DATE OF DEATH

		dilhiAN	15.0		30N					12 -	- 11	- 94		1:00 P
		4. SOCIAL SECURITY NUMBER		. AGE (In yrs. les		IF UNDE	R 1 YEAR	IF UNDER 2	4 HRS. 7.	DATE OF BI (Month, Day,	Ybar)	8.	BIRTHPLA Country)	ACE (State or Foreign
목		212-56-1126	1 □ M 2 🔀 F	100	YRS.					27 1	24-18	94 0	1981	LAND
3 should	(m)	9e. FACILITY NAME (If not institution, give s				96. CIT	0		N OF DEATH	1	9	e. COUNTY	OF DEAT	н
1, 2, 3	ЕСТОЯ	RESIDENCE OF DECEDENT	ne _			1	272-1	IMO	KE_					
Pages 1	l m	10s. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	ION					10	d. INSIDE CITY
. 	DIR	MAKYLAND			6	BAL	TEM	ORE					17	LIMITS? YES 2 NO
permit.	AL.	10e. STREET AND NUMBER					101.	ZIP CODE			1	log. CITIZEN	OF WHA	T COUNTRY?
ısı	FUNER	700 WEST 401	H STREE	T				212	2//			Us	5,A.	
020 physician. burial-transit	1 2	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS OECEDENT E FORCES? 1	YES 2 X		13.	WAS DECI	ENDENT OF	HISPANIC (ORIGIN? (Spuerto Rican.	ecify Yee or	No- 14.	RACE -	American Indian, hite, atc.
	B≤	3 Widowed 4 Divorced	IF YES, GIVE WAR	IF YES, GIVE WAR OR DATES 1 1				specify Cuben, Mexican, Puerto Rican, atc.) (ES 2 NO Specify:						NHTTE
- 6 70	8	15. DECEDENT'S EDU	CATION	16e. DE	ECEDENT'S	USUAL C	OCCUPATIO	N		165 KINE	OF BUSIN	ESS/INDUST	TRY	MILLE
T. 6 2	<u> </u>	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G	live kind of v	vork done	during mos	st of working			0. 000	200,111000		
	그로	104RS.	conogo (r v or o v y	H	OME	MAK	ER			OV	VN	Home	=	
AN the hos	once.	17. FATHER'S NAME (First, Middle, Lest)						18. MOTHE	R'S NAME	(First, Middle,				
Y L	m III	SAMES E. BL	7KE					59	WE	EDM	UND	3		
MARYLAND retained by the hospit should be detached	TO BI	190. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a	nd Number o	r Rural Route	a Number, Cit	ty or Town, S	State, Zip Coo	de)	-
be re	- Pe	F. WATT LAN	1500		3733	50	ANK	2 RV.	M	MI,	FLORI	19 7	33/3	53
E & E	must b	20a. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Rem	oval from Stata	20b. PLACE	ematory or of	her place.	SITION (Nai	ne of	l.	DATE		TION — City		
- a a		4 Donellon 5 Other (Specify)		ALL	MIN	2	$\pi u \kappa \varsigma$	H		3/94	5411	ELLA	NO. 1	MAKLANI
ALTIMOF leath, Page 6 m funeral director,	examiner	21. SIGNATURE OF FUNERAL SERVICE LIC	ZENSEE			22.	NAME AN	D ADDRESS	OF FACILITY	KIN	5 d 50	NSC	0,	•
9 =		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HENRY W. DENKENS & SONS CO. 4905 YORK R. BALTO., M. 21212.												
B. after or by the removal	medica	23. PART I. Enter the diseeses, preshock, prehaert failure.	complications that c	eused the de	eeth. Do n	ot ente	r the mod	de of dyln	g, such e	cerdisc o	or respirat	ory arrest	,	Approximete
(g) .		IMMEDIATE CAUSE (Finel	List only Die Ceuea	Dn each line										Onset and Dest
with with reletely fill cremation	, B	disease or condition recuiting in death)	Pur	Eumon	15									2 Dons
	event,			R AS A CONSE										
executed with and comple or burial, cre		Sequentially list conditions,	b	cintoles			7510	.7						2 months
Ox be es	or other traumatic	If any, leading to immediate cause. Enter UNDERLYING		FREDZAL			sauch	-6.0						
		CAUSE (Disease Dr Injury	С	R AS A CONSE			Jen en C -							
Gertif ding	Or Other	thet initieted events resulting in death) LAST	002 10 (01	TAG A CONSE	OOLINGE OF	<i>y</i> •								
_ = = =	C C		d											
RDS at the	any injury,	PART II. Other eignificent condition				n the u	nderlying	ceuse giv	ven in Per	t i. 24a.	WAS AN AU			RE AUTOPSY FINDINGS
		PAZARLEGIA		FT. VLOC-	7						YES 2	4	CO	MPLETION OF CAUSE DEATH?
	Shows	PYELONEAR											1 [YES 2 NO
We law	m Z	DID TOBACCO USE CONT	RIBUTE TO CAU	SE OF DEA	TH YE	S 🗆	NO 🗆	UNCE	RTAIN [
TA The	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	CE OF DEAT	H (Check								
F VITA SICIAN: The certificate to the State	YS Y	1 TYES 2 NO	1 Inpetient 2 E			4 Nu	rsing Home		dence 6	Other (Spe	cify)			
PHYSICIAN: The this certificate ha with the State D		27. MANNER OF DEATH 1 Natural 5 Pending		28e. DATE OF INJURY 28b. TIME (Month, Day, Year) INJUI			OF 28c, INJURY AT WORK?			28d. DESCRIBE HOW INJURY OCCURED				
	marked, BY PI	2 Accident Investigation	20 20 102 25					ES 2	_					
TISI TTEN TTEN after	Z8 IS	3 Suicide 8 Could not be 4 Homicide determined	NJURY — At ho :. (Specify)	— At home, farm, atreet, factory, office				26	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
DIV OR A DIREC hours	Tem SLE	29a. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of my	knowledge, de	ath occurre	d at the	time, date	end place, e	and due to t	he cause(s)	and manne	r as stated		
Z 72		one) 2 MEDICAL EXAMINE											use(e) an	d menner as stated.
THE HOSPITAL THE FUNERAL filed within 72	C	29b. SIGNATURE AND TITUE OF CERTIFIE							SE NUMBER					onth, Day, Year)
TO THE HOSPITE TO THE FUNERA be filed within 7	BE	all and	mm	- m					2399			_		12, 1854
FFX:	일	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type,	Print)								
4		Che as	maras III	K3	KGEN	المد	700	J. 4	5-5	34	7-10m	46, mà	2	1211

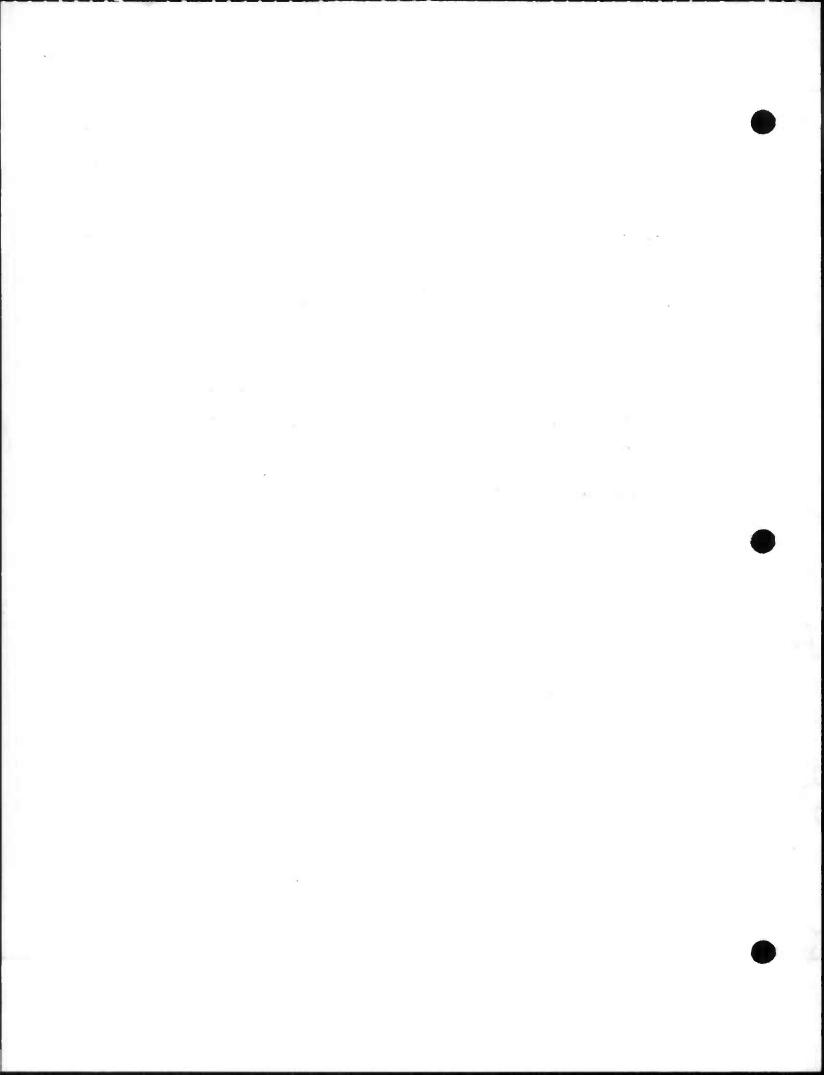
32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Lest)

DHMH-18 Rev 1/89



Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

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BE

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MEDICAL CERTIFICATION

PHYSICIAN:

В

COMPLETED

BE

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A2 RECUSTRAND SIGNATURE

BALTIMORE, MARYLAND 21215-0020

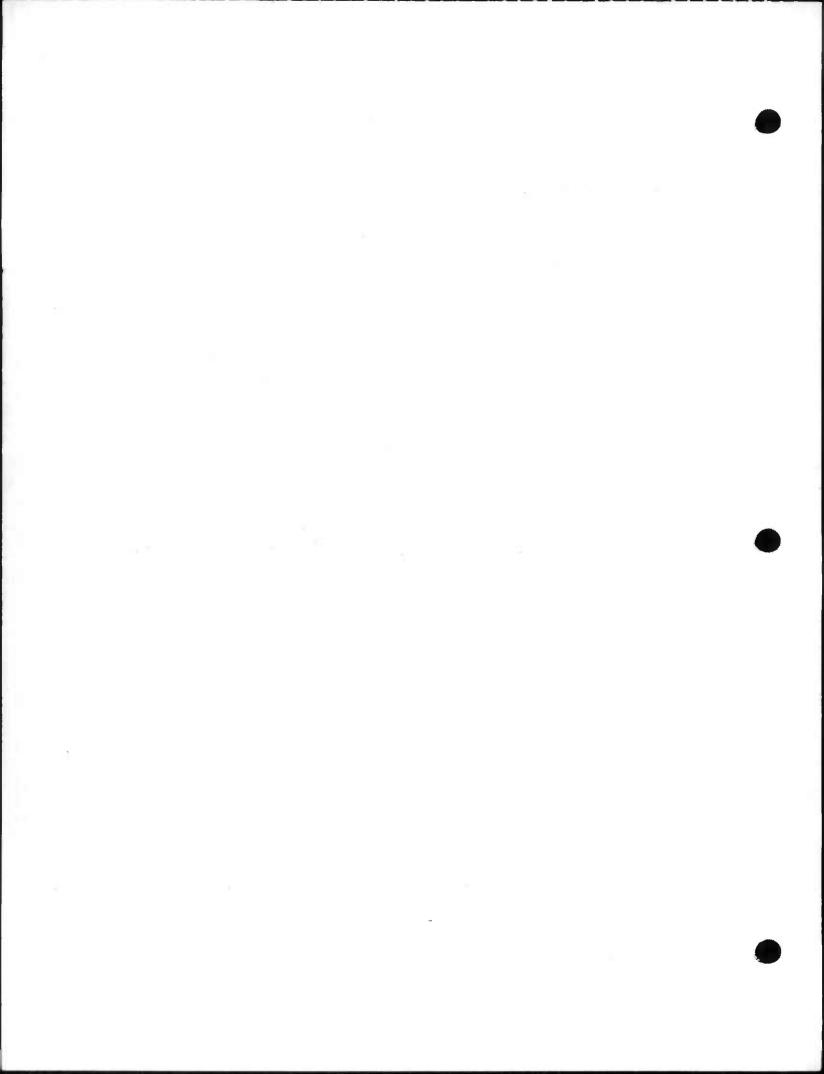
DIVISION OF VITAL RECORDS, P.O. BOX 68760

HE FUNER led within ORTANT:	O THE FUNER of filed within	TO THE PROPERTY OF THE STORY THE STORY THE STORY THE STORY THE STORY THE STORY THE STORY THE STORY OF THE STO	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
HE FUNERAL DIRECTI HE WITHIN 72 hours at ORTANT: If Item 23	THE FUNERAL DIRECTI THE FUNERAL DIRECTI FILED WITHIN 72 hours at MPORTANT: If Item 2,	CADIA	DR: Afte	fter dea	S is
HE FUNERAL D led within 72 ho ORTANT: If IN	O THE FUNERAL D F filed within 72 ha MPORTANT: If IN	2	II RECT	ours af	ет 2
HE FUNER led within ORTANT:	O THE FUNER of filed within	2	AL D	72 PG	=======================================
DRI V	MPORT	2	UNEF	vithin	ANT
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DEC. 1954 LEO MARTIN 07 2:14 Р 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year, APR . 12, 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 🕅 M 2 🗆 F 214-22-4670 68 YRS S. Carolina 1926 9e. FACILITY NAME (If not institution, give street and number, 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 1601 AISQUITH ST. BALTIMORE N/A RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore 1X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1601 N. Aisquith Street 21202 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Maxican, Puerto Ricen, etc.) 14. RACE — American Indien, Black, White, atc. FORCES? 1V YES 2 IF YES, GIVE WAR OR OATES 1 Never Merried 2 Merried Specify: Black 1 TES 2 NO Specify: 3 🕅 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KINO OF BUSINESS/INDUSTRY (Specify only highest of Elementary/Secondary (0-12) College (1-4 or 5 +) N/A Laborer Bethlehem Steel 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surneme, Nero Martin Christine 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, AVENUE, BALTIMORE, MARYLAND 21214 Leonard V. Martin 2337 IVY 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Buriel 2 Cremetion 3 Removal from State °BALTIMURE MATIONAL CEMETERY12 12 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March Funeral Home East emaa moun 1101 E. NORTH AVENUE/BALTIMORE, MD 21202 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between **IMMEDIATE CAUSE (Final Onset and Death** Cardiov ascular disease or condition_ they sclerates reaulting in death) Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1XXYES 2 NO OF DEATN? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** OTHER: OTHER:
4 | Nursing Nome 5 | Residence 8 Other (Specify) | HOME |
FOF | 28c. INJURY AT | 28d. DESCRIBE HOW INJURY OCCURED 1X WES 2 □ NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA FRIEND 27. MANNER OF GEATN 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 1 Natural 1 YES 2 NO Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Nomicide 29a. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end menner as stated. 2 😾 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) en write up O.C.M.E DEC.08,1994

111 Penn Street, Baltimore,

Maryland 21201



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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	e executed with	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 strong to remain the State Deer, of Health and Mental Horiene entor to burial, cremation, or removal.	RTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at each
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IMPORTANT: 1

4 Homicide

31. DATE FILED MEDIT Day 1648 1994

Items1,16a&b,g-718,12-13-94,perf.h.,dr FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MOZELL MOFFEETE Nozell Moffett lico Altu 94 12 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign OCT.15, CAROLINA 219-22-2493 1XXM 2 ☐ F 73 1921 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH n/a DIRECTOR HOSPITAL BALTIMORE HOME CHURCH RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MARYLAND n/a 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? STATES 21213 UNITED ELLWOOD AVENUE 1508 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—It yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: BLACK 1 TES 2 NO Specify: BY 3)(X) Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL OF HYGIENE Elementary/Secondary (0-12) College (1-4 or 5+) LABORER TH JOHN NOPKINS HOSPITAL 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) MAGGIE CRAINE MITTIE STEWART 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stein, Zip Code 0 DARLEY AVENUE, BALTIMORE, MARYLAND 21218 1104 STEWART CARL 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1X Burlal 2 Cremetion 3 Re 4 Donation 5 Other (Specify) CEMETERY12 13 LAUREL, MARYLAND NATIONAL 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE erega 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one ceuse on each line. Approximate IMMEDIATE CAUSE (Finel Onset and Death diseese or condition STRSIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): heymania CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause, Enter UNDERLYING Cardismos of CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 | YES 2 | 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 286. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Natural BY

5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be

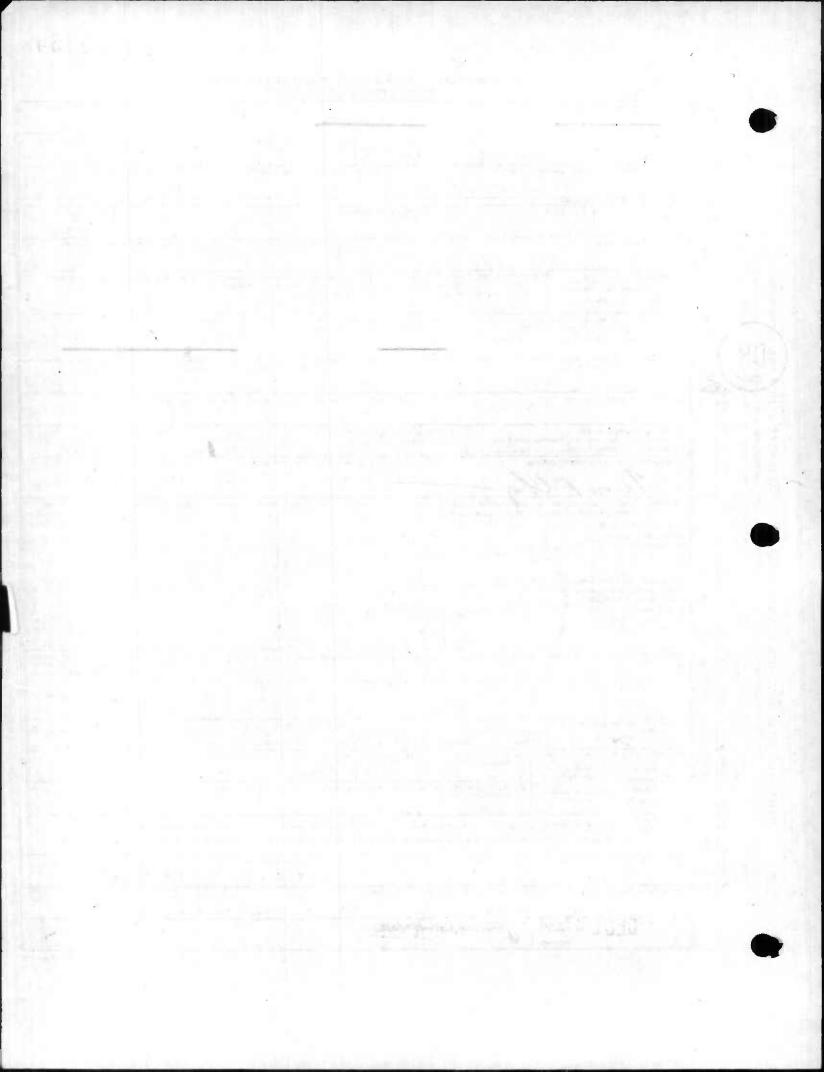
29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

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196. SIGNATURE AND TITLE OF CERTIFIER ALLOW A 17.0	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
week Albour 18.00	1043235	12/2/74

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

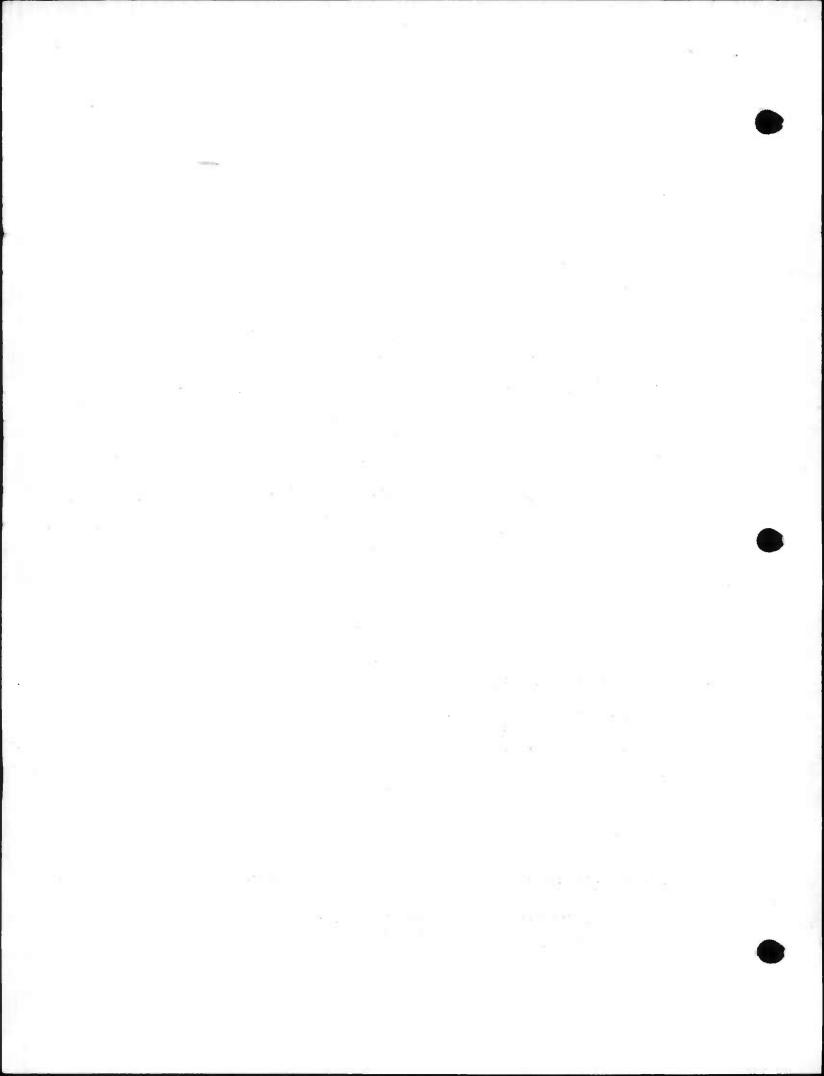
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32. REGISTRAP SEIGNATURE



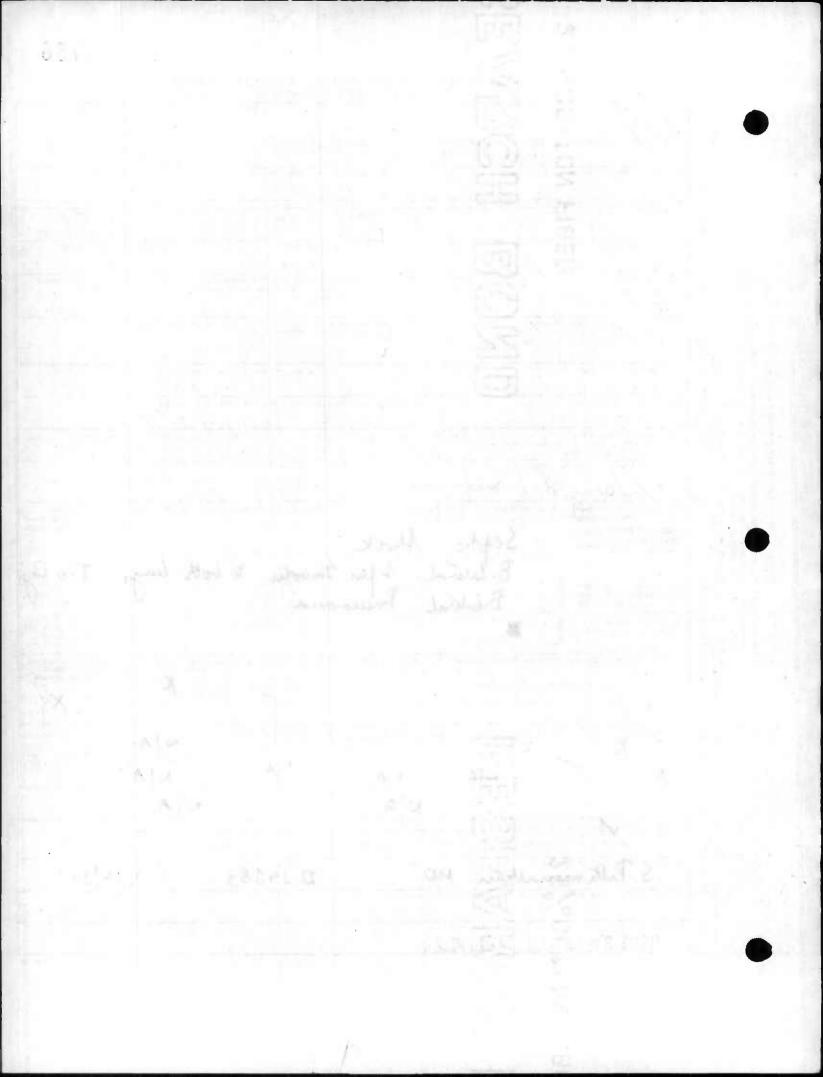
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	1. DECEDENT'S NAME (First,	Middle, Lest)						שבאו			OF DEATN			3. TIME DF DEATN
	4. SOCIAL SECURITY NUMB	reduire.	+ Mary	he.11						MONT	mber 4		YEAR G	DIIDAM
	4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTNPI	ACE (State or Foreign
	178-12-3924		1 🗆 M 2 🔀 F	90	YRS.	MONTHS	DAYS	HOURS	MIN.	Sen	29,1	904	Country)	and.
	Se. FACILITY NAME (If not ins	stitution, give stre	et and number)			9b. CITY	, TOWN D	R LOCATIO	ON OF DE				Mary	
e e	Sinai Hospit	al				В	alti	more				N/A	1	
DIRECTOR	RESIDENCE OF DEC	EDENT 10b. COUNTY												
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	MD 100. STREET AND NUMBER		/A		B	alti								X YES 2 NO
RA	2121 Windso	or Mill	Pond				107.	ZIP CODE				_		AT COUNTRY?
FUNERAL	11. MARITAL STATUS			T EVER IN U.S. ARM	150			212					5.A.	
工	1 Never Married 2		FORCES? 1	YES 2XXNC	ובט		If yes, spe	cify Cuba	n, Maxican	, Pusrto	N? (Specify Yea Rican, etc.)	or No—	14. RACE - Black, 1	- American Indian, White, atc.
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Ш	Elementary/Secondary (0-	12)	College (1-4 or 5	life. (Do NOT u	work done se retired.)	during mo:	st of workin	g					
MP	8th		N/A		N/	A					N	/A		
8	17. FATNER'S NAME (First, Mit										Middle, Maiden			
BE	Major Cornel		tchell					Mar	gare	t Kr	ox Mit	chell		
6	19a. INFORMANT'S NAME (7)										ber, City or Town			
	Edith Wright								Apt	. 14	G/Balt	imore	, MD	21218
	20a. METNOD OF DISPOSITION 1 September 2 Cremetton	n 3 Ramov	al from State	20b. PLACE AN cemetery, crem	atory or o	ther place)				DAT		CATION - C	ity or Town	ı, State
	4 Donation 5 Other		NOTE -	King N	Memo	rial					13 Rar	ndall	stown	, MD
	21. SIGNATURE OF FUNERAL	. SERVICE LICEI	Total /	8 -				D ADDRES			ne East			
	7-		10	fun	F	\Rightarrow	101	E. No	orth	Ave	nue/Ba	ltimo	re,	MD 21202
	23. PART I. Enter the dis	seeses, or co	mplications tha	caused the dea	th. Do	anter	the mo	da of dyi	ng, such	as car	dlec or respli	atory erre	et,	Approximate
	IMMEDIATE CAUSE (Fine		•											interval Between Onset and Deeth
	disease or condition resulting in desth)	→ e.	Acu	THE KEY	ral	Fail	ure							
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E	resulting in daeth) LAST					,								
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	27. MANNER OF DEATH 1 Natural 5 F	Pending	26s. DATE OF (Month, D	INJURY ly, Year)	26b. TIM	URY	28c. INJU WOI	RK?		28d. DE	SCRIBE HOW IN	JURY OCC	JRED	
2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 1 Hom														
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₩ I	(Check only 1 \$\frac{1}{2}\frac{\text{LERTIFYING PHYSICIAN:}}{\text{10} The best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as attated.													
29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and dus to the cause(a) and manner one) 2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dustonated at the time, da							dus to the	csuse(a) a	nd manner as stated.					
BE	SHINGIGNATURE AND TITLE	OF CERTIFIER	m					29c. LICE	NSE NUM	BER		29d. DATE	SIGNED (N	lonth, Day, Year)
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-	NAME AND ADDRESS OF	c 11 .		E DF DEATH (ITEM	27) (Type,	Print)	12.	11.	مر بداری					
	31. DATE FILED (Month, Day, Y	- Here	32 pediare	neu 400	p.76	U Et	. B.	ehin	uya					
	DEC 1	3 1994	Ja. HIPUIDINA	MS SIGNATURE P	volall									



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	Betty	E (First, Middle, Last) ROX 1	ANNE	M	ETG	ZER	2			MONTH		DAY	YEAR 94	3. TIME OF DEA
	4. SOCIAL SECURITY		5. SEX	6. AGE (In yrs. Ia		IF UNDER		F UNDER	24 HRS.	7. DATE (Month	OF BIRTH , Day, Year)		B. BIRTH Countr	PLACE (State or I
	9s. FACILITY NAME (II	f not institution, give	Λ	30	1110.	9h CITY	TOWN (OR LOCATI	ON OF DE	Augus	t 22.	1956	UNITY OF D	ryland
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BY FUNERAL	11. MARITAL STATUS 1 Never Merried 3 Widowed 4	2 Merried Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	T EVER IN U.S. A	RMED NO		If yes, sp		ın, Mexice	n, Puerlo I	? (Specify Ye	e or No-	14. RACE	E — American Inc. k, White, elc.
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	17. FATHER'S HAME (F		omle Cm					18. MOT			Aiddle, Maide			
8E	190, INFORMANT'S HA	S R. CL	ark. Sr.	11	b. MAILIHO	ADDRESS	(Street a	and Numbe			te You		(in Code)	
5	Anna Wri										o., M		21230	
	20a. METHOD OF DIS		moval from State	20b. PLACE	AND DATE	OF DISPOS	ITION /NE	ama of		DAT	E 20c. L	OCATION -	- City or To	
	4 Donation 5	Other (Specify)		The	Green					12/	7 Ba	ltimo	ore,	Md.
	21. SIGNATURE OF FU	HERAL SERVICE L	ICENSEE	1				HD ADDRE		CILITY				
	Gary L. Kaufman Funeral Home of Elk., In 5695 Main St., Elkridge, Md. 21227													
	IMMEDIATE CAUS	, or heald/failure E (Finel on	Liet only one can	at coused the duse on each lin	eath. Do	not enter	the mo	ode of dy	ing, suc	h ss card	llac or rest	piratory s	rrest,	Approxi
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DIVISION OF VITAL RECORDS, P.O. BO) OR ATTENDING PHYSICIAN: The law

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I'dl.	The function and the strength of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ALVERT 0900 DECEMBER 12 1994 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH
(Month, Day, Year)
April 13,1904 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (Stete or Foreign 15-42-731 MONTHS DAYS HOURS MIN 90 1 - M 2 X F Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore 1 TYES 2 NO Catonsville FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 19g. CITIZEN OF WHAT COUNTRY? 334 Stonewall Road 21228 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

t YES 2 NO Specify: 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried BY Specify: 3 X Widowed 4 Divorced White 9 15. OECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ast of working COMPLET Elementary/Secondary (0-t2) College (t-4 or 5+) 9th Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Peter Ament Katherine Erap BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 213 Sanford Avenue Frank Joseph Martin, Jr. Catonsville, MD 21228 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Buriel 2 Cremetion 3 Removal from Stala Lorraine Park Cemetery 12/15/94 Donation 5 Other (Specify) Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAWN F. McDonald 22. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home, P.A. 301 Frederick Rd Baltimore MD 21228 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, Approximate shock, or haert fallure. List only one ceuse on aech line. interval Retween IMMEDIATE CAUSE (Fine) Onset and Dasth disesse or condition ASpiration
DUE TO (OF AS A CONSEQUENCE OF): Odays reaulting in death) Dementia PHYSICIAN: MEDICAL CERTIFICATION Sequentisity ilst conditione, DUE TO (OR AS A CONSEQUENCE OF): If sny, lasding to immediate cause. Enter UNDERLYING On phanyngeal DUE TO OR AS A CONSEQUENCE OF: CAUSE (Disease or Injury that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? obstructive disease aimay 1 TYES 2 TO NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: I YES 2 NO 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO ВУ 2 Accident 26e. PLACE OF INJURY — At home, larm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide ED 6 Could not be 4 Homicide determined ET

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(e) end menner ea stated.

2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

2066

BALTIMORE, MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR R. PANDE AGNES HOSPITAL,

Klande

31. DATE FILED (Month, Day, Yeer) 32. REGISTRAR'S SIGNATURE 3 1994

Davidson Randall

12/12/94

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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Mary Magdalene Mills 1994 December 10. 9:30 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH (Month, Day, Year, DAYS HOURS MIN. 1 M 2 F 219-22-7320 YRS 11/20/1926 West Virginia 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR # Johns Hopkins Bayview Med. Ctr. Baltimore City RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 YES 2 TYNO Dundalk permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 7807 St. Fabian Lane 21222 United States Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2-NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian Black, White, atc. FUNCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced use as the White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16h. KIND OF BUSINESS/INDUSTRY for Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years page 5 should be detached Homemaker Own Hame 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Steve Politakis Maude Doss 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mr. Cecil Mills, Sr. 7807 St. Fabian Lane Dundalk, Maryland pe 20e METHOD OF DISPOSITION
14 Burlal 2 Cremation 3 Removal from Stale 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must funeral director, Holly Hill Mem. Gdns.12/13/94 4 Donation 5 Other (Specify) Middle River. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dundalk Duda-Ruck Funeral Home of Dundal Inc. 7922 Wise Ave. the Dundalk. Maryland 21222 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate filled in by shock, or haart failure. List only one cause on each line interval Batween 0 IMMEDIATE CAUSE (Final Onsat and Death the cremation, Acute Myocaedial importan disease or condition completely event. resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF): executed to burial, traumatic CERTIFICATION and Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if sny, lasding to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSPOUENCE OF) that initiated events reaulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AVAILARI E PRIOR TO Aue CARCINOMA Lung. COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO Shows CONGESTIVE HI FAILM RE 1 YES 2 NO been I. of J DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN **PHYSICIAN:** has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item HOSPITAL OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO Inpetiant 2 - ER/Outpetient 3 - DOA 10 27. MANNER OF DEATH 28s. OATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, this (1 Natural
2 Accident 5 Pending 1 YES 2 NO ВУ After Investigation 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED DIRECTOR: J 4 Homicide 28 Item 29a: CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. THE HOSPITAL D THE FUNERAL D filed within 72 ho = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MD. 一七。 D21859 12/12/94. 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMON TARIMO BLYMA 6710 HolaGird FVE 2/222. Sandan Kardell 31. DATE FILED (Month, Day, Year) DEC 13 199

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

2.7 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the property of the HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	ITEMS: 15,19a, PER F.H								
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND E OF DEATH	MENTAL HYGIEN REG. NO	_			
	1. DECEDENT'S NAME (First, Middle, Last)					AY YE	3. TIME OF DEATH		
	Alvin 4. SOCIAL SECURITY NUMBER 5.		lorris		Dec. 08	,1994	12:45 P M		
	218-46-9198	6. AGE (In yrs. lost	YRS. MONTHS	DAYS HOURS MIN.	7, DATE OF BIRTH (Month) Day, Year)		SHITTHPLACE (State or Foreign		
TOR	90. FACILITY NAME (If not institution, give street MANY AN GEN RESIDENCE OF DECEDENT	erel Hospita	96. CITY,	Baltimus		9c. COUNTY	OF DEATH		
DIRECTOR	Mary and 100. COUNTY		10c. CITY, TOWN O	or Location timore			10d. INSIDE CITY LIMITS?		
	100. STREET AND NUMBER		1940	101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
FUNERAL	914 Edmonds			212			USA		
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES	0 1	WAS DECENDENT OF HISPA If yee, specify Cuben, Mexic 1 YES 2 NO Spec	en, Puerto Ricsn, atc.)	s or No— 14.	RACE — American Indian, Black, White, etc.		
TED	15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted) (Gh	CEDENT'S USUAL OF we kind of work done of Do NOT use retired.)	CCUPATION during most of working	16b. KIND OF BU	SINESS/INDUST	RY		
COMPLETED	7-12	College (1-4 or 5+)	,	ployed					
BE CO		rris		1 /	AME (First, Middle, Meiden	Surneme)	•		
10	199 INFORMANT'S NAME (Type/Print) BRENT	DA MORRIS 19b 3	MAILING ADDRESS	Prinadale	Ave, Bal	U	d 2/2/6		
	20 METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	20b. PLACEA cemetely crem	ND DATE OF DISPOS	m PK	20c. LO	Balto	or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	L. Russ	22)	NAME AND ADDRESS OF F. 05-6/h L 252 W.	NORTH QUE	Finer Bal	al HM to, Md 21216		
	23. PARTA Enter the diseases, or come ahock, or heert fallure. List	mplications that caused the design only one cause on each line.	th. Do not enter	the mode of dying, su	ch as cardiec or resp	ratory erreat,			
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	USE (Finel Infectious Endocardițis-involving Fricu							
	a	DUE TO (OR AS A CONSEO	UENCE OF):				1 week		
TIFICATION	Sequentially list conditions, If any, leading to immediate	Staphy Loc		ureus			years		
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	IV Drug Ab	use						
FI	that initiated eventa reaulting in death) LAST	DUE TO (OR AS A CONSEO	UENCE OF):						
CEF	PART II. Other algnificant conditions of	contributing to death but not re	eulting in the us	deriving ceres given is	Part I, 24a. WAS AN	AUTOREY T	24b. WERE AUTOPSY FINDINGS		
MEDICAL	DKA, AIDS, Se				PERFOI	RMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE		
MED	Renal Failure		a acher	C BIIIDULL	1 _ YES 2	X	OF DEATH?		
ä	DID TOBACCO USE CO	ONTRIBUTE TO CAUS	E OF DEAT	TH YES NO					
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	tOSPITAL: ∭ Inpatient 2 ☐ ER/Outpatient 3	OTHER	26. PLACE OF DEATH (C	heck only one)				
PHYSICIAN:	t YES 2X NO 1	N Inpatient 2 ☐ ER/Outpatient 3 ☐ 28e. DATE OF INJURY	26b, TIME OF	sing Home 5 Residence 28c, INJURY AT	6 Other (Specify)	N IIIBY OCCUBE	-n		
	1 Natural 5 Pending	(Month, Day, Year)	INJURY M	WORK?					
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined	26e. PLACE OF INJURY — At hor building, atc. (Specify)	tory, office	281. LOCATION (Street City or Town, State)	end Number or R	lural Route Number,			
E	290. CERTIFIER	N. T. Market and C. C. C. C. C. C. C. C. C. C. C. C. C.							
COMPLETED	(Check only	N: To the beat of my knowledge, dea On the beele of examination end/or in					use(e) and manner se stated.		
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	^ ^		29c. LICENSE NU			GNED (Month, Day, Year)		
10 BI		D. questro		8922	9	D 12	18/94		
Proc.	30 NAME AND ADDRESS OF PERSON WHO C	TOMBI CTED CALLES OF DEATH STEN	070 CT D-1-41						

c/o Maryland General Hospital



DEC1 3 1994

32. REGISTRAR'S SIGNATURE

M.D.

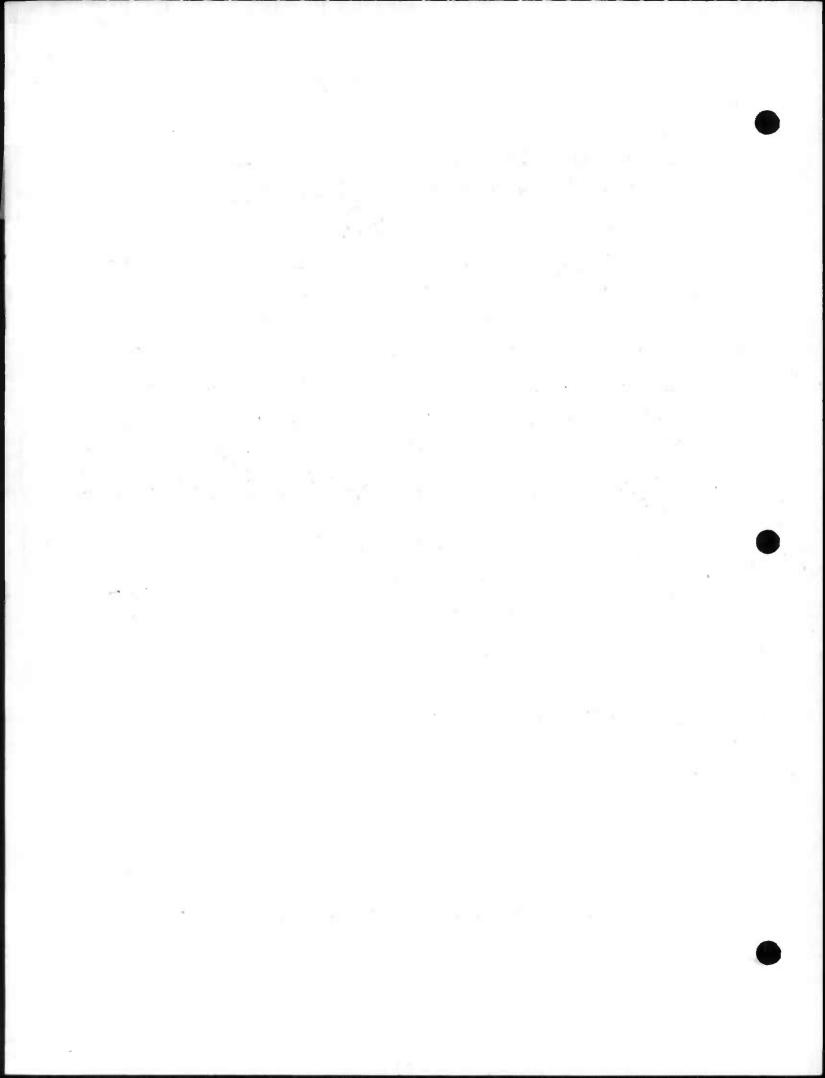
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typa, Print)

Geetha Dhinakaran,

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
R	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMEN	T OF HEALTH AI E OF DEATH	ND MENTA	AL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE	E OF DEATH		3. TIME OF DEATH				
	Charles	Moone	У		De		994	4:05 P M				
	4. SOCIAL SECURITY NUMBER 219-01-1434 9e. FACILITY NAME (If not instituting, give sm	5. SEX 1 M 2 F 6. AGE (In yrs. las	YRS, MONTHS	R 1 YEAR IF UNDER 24 F DAYS HOURS M	Jul Jul	OF BIRTH	6. BIRT	HPLACE (State or Foreign try)				
DIRECTOR	Maryland Gen RESIDENCE OF DECEDENT	eval Hospila		Baltin	none	90.	COUNTY OF I	DEATH				
	100. STATE 100. COUNTY MAY AND NUMBER		15a	OR LOCATION LIMONE 101, ZIP CODE		la	0.77.75.4.05	10d. INSIDE CITY LIMITS? 1 YES 2 NO WHAT COUNTRY?				
FUNERAL	714N. arlingto	AVENUE 12. WAS DECEDENT EVER IN U.S. AB	WAS DECENDENT OF H	U.	SA							
Β¥	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 NO SERVICE STATES	If yes, specify Cuben, N			Blec	E — Americen Indien, ik, White, etc.					
COMPLETED	15. DECEDENT'S EDUC, (Specify only highest grade of Elementary/Secondary (0-12)		OCCUPATION during most of working	TION most of working 166. KIND OF BUSINESS/INDUSTRY Ros-turgart								
	17. FATHER'S NAME (First, Middle, Last)	ned		18. MOTHER	S NAME (First,	Middle, Malden Surnar	ne)					
BE	19a. INFORMANT'S NAME (Type/Print)	19/	b. MAILING ADDRES	S (Street end Number or I	Rural Route Nun	nber, City or Jown, Stell	, Zip Code)					
٩	Dorothy Moons 20a METHOD OF DISPOSITION 1 & Burlel 2 Cremation 3 Remove	ex 7	14 n. A	dington	dre	Batto	Md	21217				
	4 Donation 5 □ Other (Specify)	Val from State cemetric cre	AND DATE OF DISPO halory of other place		1/3	GU Wes	porti	Md.				
	21. SIGNATURE OF FUNERAL SERVICE LICE	R. Russ)	NAME AND ADDRESS OF	Unor	ss fen	Batto	Hen				
- 1	23. PART Enter the diseases, or co shock, or heart fellure. L	omplications that caused the de ist only one cause on each line	eath. Do not ente	r the mode of dying,	auch aa car	diec or respirator	errest,	Approximate interval Between				
	IMMEDIATE CAUSE (Final											
	resulting in death) s.	•		.rure				unknown				
Z	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions b. Cardiomyopathy											
E	If sny, leading to immediate											
길	CAUSE (Disease or injury											
CERTIFICATION	that initiated events resulting in desth) LAST		5.7.					į				
	DATE II Other slevilleant and the											
PHYSICIAN: MEDICAL	PART II. Other significent conditions	contributing to deeth but not r	resulting in the u	nderlying csuse give	n in Part i.	24a. WAS AN AUTOI PERFORMED?	PSY 241	AMILABLE PRIOR TO				
ED						1 TES 2 NO	·	OF DEATH?				
Σ.	DID TOBACCO USE C	ONTRIBITE TO CALL	SE OF DEA	TH VES [NO []			1 TYES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL	CHIRDOIL TO CAU	JE OI DE	26. PLACE OF DEAT		nel						
SIC		HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3	DOA 4 Nu									
¥	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	26c. INJURY AT		SCRIBE HOW INJURY	OCCURED					
BY	1 Natural 5 Pending 2 Accident Investigation	(worth, buy, rour)	M	WORK?	0							
	3 Suicide 8 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY — At ho building, atc. (Specify)	me, farm, street, tec	ctory, office	28f. LOC City	CATION (Street and Nu. or Town, State)	mber or Rural	Route Number,				
COMPLETED		IAN: To the best of my knowledge, da						e) end manner ee stated.				
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	House	+ 620	29c. LICENSI		29d.		(Month, Day, Year) -08-94				
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OEATH (ITE	M 27) (Type, Print)	77 092	- J		12	- 00-54				
	Shelonitda R	Rose, M.D. c/c		and Gene	ral H	ospital						
	31. DATE FILED (MONT) 1994	A PERSONAL PROPERTY.										



ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-719 1/31/95 t.t.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF GEATN 3. TIME OF DEATN 3:51 CLARENCE McNEILL DEC 94 PM 6. AGE (In yrs. last birthday, 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign 19-1 1 1 M 2 | F Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR APPLETON STREET BALTIMORE CITY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Yland nore 1 VES 2 NO permit. 100. STREET AND NUMBER FUNERAL 101. ZIP CODE WHAT COUNTRY? nours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. **MARYLAND 21215-0020** If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES BY Specify 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life, Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify (0-12) COMPL amine once. 17, FATHER'S NAME (First, Middle 16. MOTNER'S NAME (First, Middle, Ħ BE notified 2 pe 20b. PLACE AND DATE OF DISPOSITION (A 12/8/6 must 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL REPVICE LICENSEE 22. NAME AND Joseph 2222 Home 21216 or removal. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on sech line. and completely filled in by Approximate interval Between ACUTE AND CHRONIC ALCOHOLISM ASSOCIATED WITH FATTY LIVER IMMEDIATE CAUSE (Finel Onaat and Death disease or condition resulting in death) . AND SUBDURAL HEMATOMA executed within event, crem DIVISION OF VITAL RECORDS, P.O. BOX 68760, OUE TO (OR AS A CONSEQUENCE OF): prior to burial, traumatic CERTIFICATION Sequentially list conditions. QUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate physician OR ATTENDING PHYSICIAN: The law requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other the attending phy I Mental Hygiene p OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 10 shows any injury, signed by the a Health and Men PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLETION OF CAUSE YES 2 NO 1 TES 2 NO certificate has been the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) EXAMINER? HOSPITAL 1 X YES 2 NO OTHER 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 10 the 27. MANNER OF DEATN 28e. OATE OF INJURY (Month, Day, Year) 286. TIME OF 26c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED this co 28 is marked, 1 Natural 5 Pending 1 YES 2XX NO 2-2-94 FOUND Р SUBJECT FELL TWO DAYS AGO ВУ death 2 XXAccident Affer 28e. PLACE OF INJURY - At home, ferm, 3 Sulcide 6 Could not be 281. LOCATION (Street end Number or Rural Route Number DIRECTOR: / COMPLETED City or Town, Stete) 017 N. APPLETON ST. 4 Nomicide FOUND AT HOME MD Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner as attated. TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 h and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner as stated 296. SIGNATURE AND TITLE OF CERT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. DEC 3,1994 2 NAME AND ADDRESS OF PER ON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) Gov 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, day, DEC1 3

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HUSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENT	AL HYGIEN	E				
j	1. DECEDENT'S NAME (First, Middle, Last)	LINWOO		ORE		MON	E OF DEATH	94	EAR	3. TIME OF OEATH		
			'In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DAT	E OF BIRTH	8.	BIRTHP!	LACE (State or Foreign		
		M 2 🗆 F	43 YRS.			04	1- 20-5	1 N		ZLAND		
DIRECTOR	9a. FACILITY NAME (If not institution, give street 1524 E. Presto RESIDENCE OF DECEDENT	3			TIMORE		Y	9c. COUNTY	ONE			
REC	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT					IOd. INSIDE CITY			
	MARYLAND NOI	NE		BAL	CIT	Ϋ́		1	YES 2 NO			
FUNERAL	100. STREET AND NUMBER 826 N. BOND STR	EET		101	5				STATES			
BY FUN	11. MARITAL STATUS 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	RMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 NO Specify:						- American Indian, White, atc. AMERICAN		
ED	15. DECEDENT'S EDUCATI (Specify only highest grade con	18a. DECEDENT'S I	JSUAL OCCUPATION done during mo	ON et of weeking	16	Sb. KIND OF BUS			AMERICAN			
COMPLETED	Elementary/Secondary (0-12) C	college (1-4 or 5+)	life. Do NOT use	retired.)								
N C	10TH 17. FATHER'S NAME (First, Middle, Last)	NONE	U	NEMPLO				UNEMP	LOY	ED		
	WILBERT THOM	PSON			18. MOTHER'S NA							
) BE	19a. INFORMANT'S NAME (Type/Print)	DON	19b, MAILING	ADDRESS (Street a	nd Number or Rural		NNA MO		rde)			
5	ANNA MOORE		826		ND STRE					21205		
	20a. METHOD OF DISPOSITION 1	from State 20b	PLACE AND DATE O	FDISPOSITION (Na Der place) CEMET		1	94 B	ALTO.		n, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENS Calvin B		of n	CALV.	IN B. S	CRU	GGS F	JNERA	L H	OME D.21213		
	23. PART i. Enter the diseases, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line.											
	IMMEDIATE CAUSE (Final	HIV Wa	30.40 170.50	Sundr	ine					Onset and Daath		
		A -	CONSEQUENCE OF	:								
ON ON	Sequentially list conditions,	OUE TO (OR AS A	CONSEQUENCE OF	:						Zyeas		
CAT	if any, leading to immediata cause. Enter UNDERLYING											
CERTIFICATION	CAUSE (Disease or Injury that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	:								
	PART II. Other algolificant conditions of	ontributing to death b	ut not resulting in	the underlying	cause alven in	Dort I	24a. WAS AN	ALITONOV	T			
PHYSICIAN: MEDICAL	Esophageal Car	volidiasis	- 1		Abuse		PERFOR	MED?	o o	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO DMPLETION DF CAUSE OF DEATH? YES 2 NO		
ž	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	NO [UNCERTAI	N \square			·	1129 2 110		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEATH	(Check only one)								
IXSI	1 YES 2 NO 1	Inpetient 2 ER/Outp	atlent 3 DOA	4 - Nursing Hom	e 5 🗆 Rasidenca							
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		RK?	28d. DI	SCRIBE HOW I	IJURY OCCUR	ED			
	3 Suicide 8 Could not be datermined	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, st	reet, factory, office		28t. LO Cit	CATION (Street a y or Town, State)	nd Number or	Rural Rou	ite Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN ONE) 2 MEDICAL EXAMINER: 0								oue e/e) e			
	29b. SIGNATURE SNOTTHLEGO CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Vear)											
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5	30. NAME AND ADDRESS OF PERSON WHO CO	Gallant	- MD	Print)	N. Wo	160	St. C	1	Ball	more MD		
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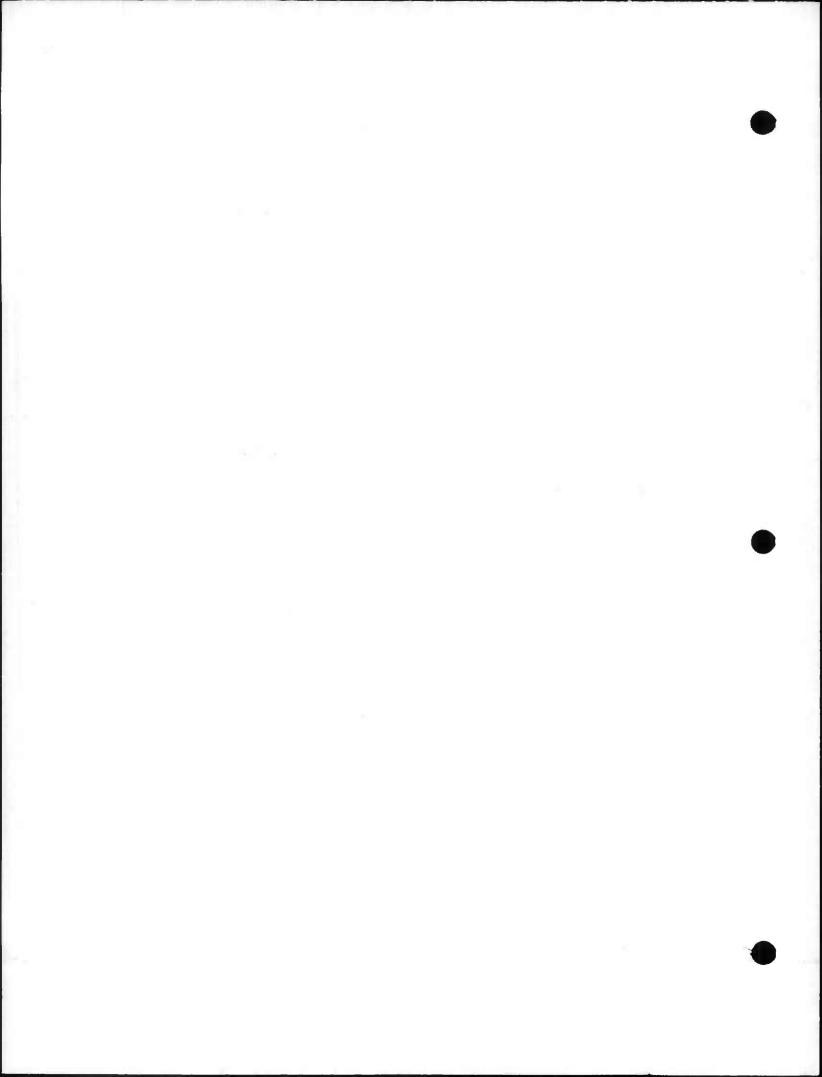
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IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last) Catherine	Mitchell	2. DATE OF DEATH DAY

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH															
	Catherine				Mit	tchell				MONTH DAY YEAR				2.00 D M		
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In	yrs. last b	oirthday)	F UNDER 1	YEAR	IF UNDE	R 24 HRS.	7 DA	TE OF BIRTH			2:00 P. M	
- 1	250-60-6768		1 M 2 X F	77			ONTHS	DAYS	HOURS	MIN.	Auc	onth, Day Year)	917	Count		
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DIRECTOR	RESIDENCE OF DECE							1111	1000		LCY			HOWC	itu	
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ā	S. Carolina	S	umter		- 1			Sui	nter				LIMITS?			
A	10e. STREET AND NUMBER				10f. ZIP CODE								10g. CIT	TIZEN OF	EN OF WHAT COUNTRY?	
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BY F	1 Never Married 2 Ma 3 Widowed 4 Divorce		FORCES? 1						ecify Cubi			to Ricen, etc.)		Spec	k, White, etc.	
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딛	15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				ina	1	16b. KIND OF BU	SINESS/IN	DUSTRY			
Щ	Elementary/Secondary (0-12) College (1-4 or 5+)				life. D	o NOT use i	etired.)					TT 1 - 1	a 1	,		
MP						Eco						High :	Schoo	ΣŢ		
COMPLETED	17. FATNER'S NAME (First, Middl							,	st, Middle, Meider	Sumame)						
BE	Maxie Grooms Sr. Lula Gee															
5	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) A124 Lionbords County Filliporth City Montal 21042										3 04040					
	Charles R. Mitchell Jr. 4124 Henhawk Court Ellicott City Maryland 210										land 21042					
	20a. METHOD OF DISPOSITION 1															
	4 Donation 5 Other (Sp 24. SIGNATURE OF FUMERAL S		-	Sar	isbur	ry Ce				14-9		Tim	nons	/ille	, S.C.	
	21. SHUMATURE OF FUMERAL S	JULE LICES	J. ~	1					M &			1 C Wit	zke i	Fune	ral Homes	
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	23. PART I. Enter the dise	asea, or co	mplication the	t caused	the dest	th. Do not	entar 1	ne mo	da ol dy	ing, auc	ch aa c	ardiac or reap	Iratory a	rreat,	Approximate	
	23. PART I. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) e. Respiratory Arrest IMMEDIATE IMMEDIAT															
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	resolding in death)	0.	DUE TO	(OR AS A	CONSEQU	ENCE OF:	_								T. T. T. C. E. C. C.	
z	Pulmman Metastases 2 maths															
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2	CAUSE (Disease or Injury C. Bladdle Carcinoma (Transity mallell) year															
	that initiated events DUE TO (OR AS A CONSEQUENCE OF):															
CERTIFICATION	resulting in death) LAST															
	PART II. Other significent	conditions	contributing to	deeth bu	t not res	sulting in	the und	eriyind	ceuse	alven in	Part I.	24a. WAS AF	AUTOPSY	, 241	o. WERE AUTOPSY FINDINGS	
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PHYSICIAN:	EXAMINER?	1	HOSPITAL:	MS eri			THER:			/						
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à l	2 Cutatta	estigation	28a. PLACE C	F INJURY -	- At home	e, ferm, stre	et, factor				281. L	OCATION (Street	and Numbe	or or Rural	Route Number	
	_ 0 _ 00	uld not be erminad	building,	atc. (Specif	ly)						C	Sity or Town, State)			
COMPLETED	29a. CERTIFIER	VINC BUYOU	All. We also be as a							1 1 1 1 1 1 1						
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BE	296. SHENATONE KHO SETLE OF	CHITTIFIER	MAT)					29c. LIC	ENSE NUI	MBER	. 0	29d. DA	TE SIGNED	(Month, Day, Year)	
P	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AMY H. GOLDON MI) 10755 Falls RD STE 360 Withwill, MD 21093-4569								194							
	30. NAME AND ADDRESS OF PI	A IOA	COMPLETEO CAU	SE OF DEAT	TN (ITEM	27) (Type, Pr	rint)	4	11	1.	11	010	01	167	- U569	
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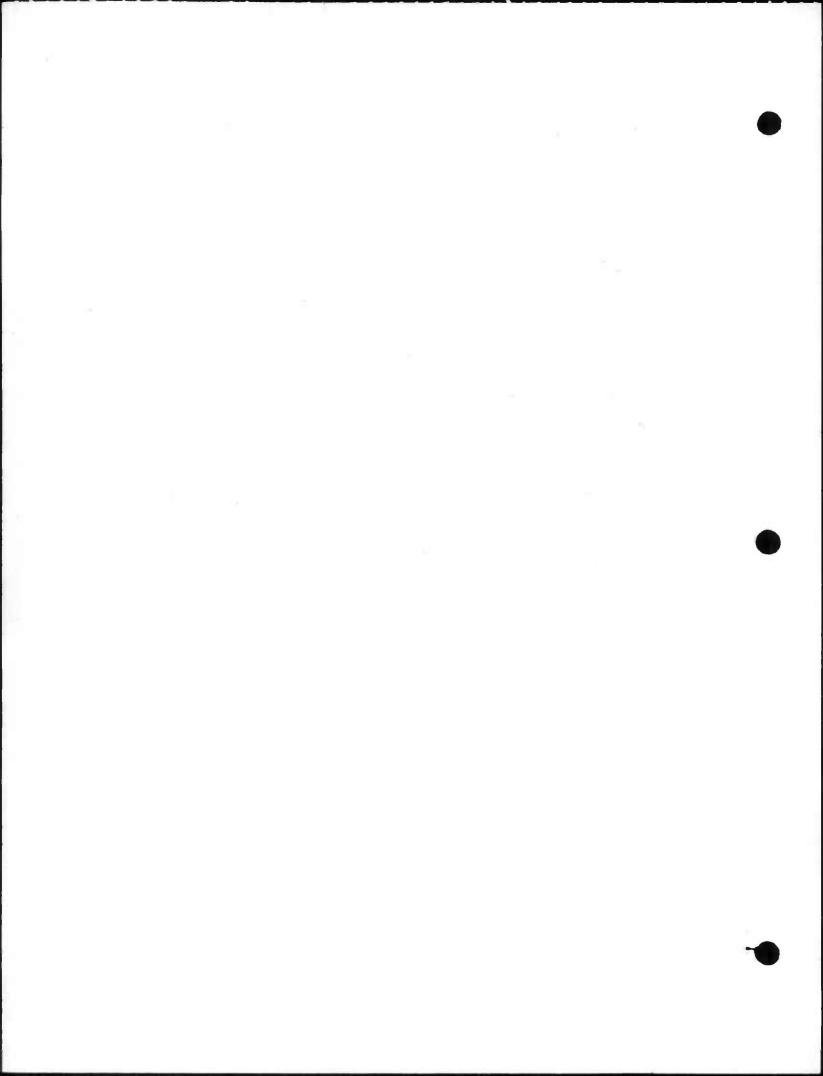
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

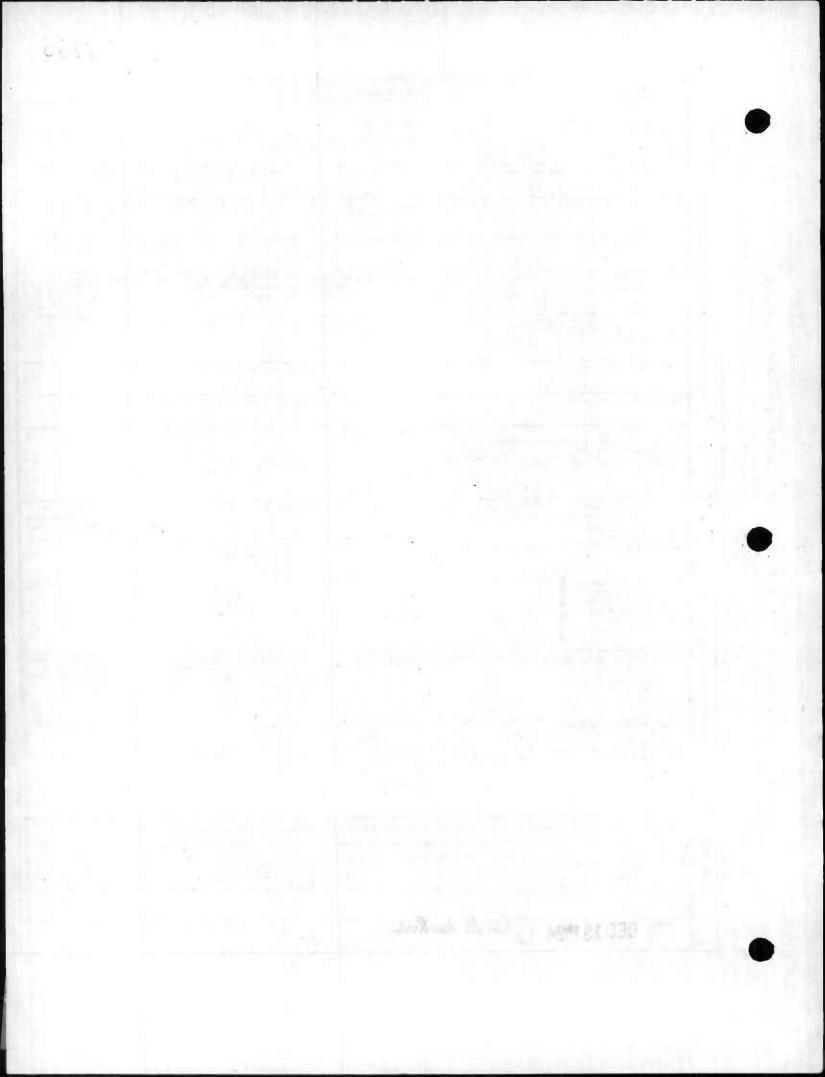
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	OR Al	DIREC	a lied wern 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tem
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	#10	H.O	1	MP09

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		MENT OF H			YGIENE EG. NO.					
	1. OECEOENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH	20.747	3. TIME OF OEATH			
	Harry E. Merrifie	ld, Jr.				Dec.	BAY 3	L994	M			
			lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E (Month, De	HRTN	S. BIRT	NPLACE (State or Foreign			
1	217-18-5537 1 9e. FACILITY NAME (If not institution, give stree	XM 2	YRS.	MONTHS DAYS	HOURS MIN.	Feb.	27,1924		aryland			
œ	Franklin Square H				R LOCATION OF DI	EATN		Baltin				
DIRECTOR	RESIDENCE OF DECEDENT	33b1041		1108	SATITE			Jateti	liore			
REC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT					10d. INSIDE CITY LIMITS?			
	Maryland Balt:	imore		HOS	edale			1 YES X X X				
3AL	10e. STREET AND NUMBER			101	ZIP CODE		10g.	WHAT COUNTRY?				
FUNERAL	8128 Callo Lane				21237							
F	11. MARITAL STATUS 1:	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (S	pecify Yes or No- i, etc.)	- 14. RAC Blac	E — American Indian, ck, While, etc.			
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 🗌 YES	2 NO Specif	y:		Spec	White			
ED	15. OECEDENT'S EOUCAT	OECEDENT'S U	SUAL OCCUPATION	PN .	16b. KIN	D OF BUSINESS	I	WIII				
Ē	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5+)	(Give kind of wo	rk done during mo retired.)	st of working							
MPL	llth grade		Railro	ad Engi	neer	Am	ntrack					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA			e)				
BE	Harry E. Merrifie	ld, Sr.				ıde DeB	0					
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural							
	Gladys Merrifield											
	20 METHOD OF OISPOSITION 1 Burlel 2 Cremetion 3 Remova	I from State 20b. PLA cametery.	CE AND DATE OF	DISPOSITION (Na	y 12-12-	OATE Q'/	Baltin					
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN:		TRWOOD		D ADDRESS OF FA		Dalui	iore,	nu.			
	Lassahn Du	2.51		Lass	ahn Fune	ral Ho						
				7401	Belair	Rd. Ba	ltimore	, Md.	21236			
	23. PART i. Enter tha diseases, or comehock, or haert failure. Lia	t only one ceuse on each	ilina.	t anter tha mo-	de of dying, euc	h as cerdiec	or reepiratory	arreat,	Approximate interval Between			
	IMMEDIATE CAUSE (Final Onset and Death											
1	reaulting in death) a	OULMONORA DUE TO (OR AS A CON	A LIMUL	ourm)								
_	and the same of th	Chronic obsta	utian	hulmi	munuad	INDA NO						
일	Sequantially list conditions, if any, leading to immediate	OUE TO (OR AS A CON	SEQUENCE OF)	Trum	mass a	www.						
CA	cause. Entar UNDERLYING CAUSE (Disease or injury											
빌	that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEQUENCE OF):									
CERTIFICATION	d											
AL (PART ii. Other significant conditions of	ontributing to death but no	ot reauiting in	tha underlying	cause given in	Part I. 24a	. WAS AN AUTOPS		. WERE AUTOPSY FINDINGS			
	Metabolic bone de	sease				10	PERFORMED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?			
ME	Vialetes melli	us)							1 TES 2 NO			
ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF D	EATH YES	□ NO □	UNCERTAIL	N						
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. P		(Check only one)								
ıysı		☐ Inpatient 2 ☐ ER/Outpatient	3 1 DOA 4	□ Nursing Nome	5 🗆 Residence							
	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Yeer)	28b. TIME INJU	RY WO	RK?	28d. DESCRIE	BE NOW INJURY	OCCURED				
B	2 Accident Investigation	28e. PLACE OF INJURY — A	home form etc		ES 2 NO	004 1 004740						
COMPLETED	3 Suicide 8 Could not be determined	building, etc. (Specify)	troine, term, str	eet, factory, office		City or To	N (Street and Num wn, State)	ber or Hurai	Houte Number,			
91	29e. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of my beautiful.										
ğ		N: To the best of my knowledge, On the best of exemination and							a) and manner as stated			
BE	Boston 1	MR			D 28		29d, L	12	(Month, Day, Year)			
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)								7 7 7				
	Jose Boston, M. D	. Union Memor	ial Hos	spital E	Balto., N	1d. (5	54-2416	3)	1			
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE												
	DEC1 3 1994 Julia Savilson Rarball											



	14/11/1		Willi					ille	r	2. DATI	E OF DEATH]	AY		3. TIME OF	
1	WILL!		5. SEX		MIL					DE		0 199	/	2 "	
	189 12 65		1 X M 2 F	6. AGE (In yrs. las	YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE	of BIRTH		Country	PLACE (State y)	
	9a. FACILITY NAME (If not			12	THS.						14-22	7		nsylv	
or.				1				OR LOCATI							
СТОВ	Bon Sec		ноѕріта	1			ват	timo	re		na				
C	10e. STATE	10b. COUNT	TY		10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE	
DIRE	Maryland	1	na		Ва	alti	mor	e						LIMITS	
AL	10e. STREET AND NUMBER	R					101	f. ZIP COD	E	10g. CITIZEN					
E	Park Mano	or Nu	rsing He	ome				212	217				USA		
BY FUN	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 1 Div		FORCES?	NT EVER IN U.S. AR 1 YES 2 I WAR OR DATES			If yes, sp	CENDENT Coecify Cube	m, Mexica	n, Puerto	N? (Specify Yes Rican, etc.)	or No — 1-	No- 14. RACE - American Indian Black, White, etc. Specify: White		
9	15. DE (Specify or	15. DECEDENT'S EDUCATION 16a (Specify only highest grade completed)					CCUPATIO	ON ast of working	na	16	6. KIND OF BU	SINESS/INDU	STRY		
E	Elementary/Secondary		College (1-4 or 5	Ma	(Give kind of work done during most of working life. Do NOT use retired.)										
COMPL	6th				Laborer							tíon-	-St	ate	
00	17. FATNER'S NAME (First, I	Middle, Last)						18. MOT	HER'S NA	ME (First,	Middle, Maiden	Sumame)			
BE	Harry M							Ne	e11;	e P	earl	Unkno	own		
0	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
-	Edward I		11 Mill	er	1170) NE	nti	coke	a St	ree	t Bal	timos	re l	MD.21	
	20e. METNOD OF DISPOSI 1 Burlet 2 Cremet	tion 3 - Ren	moval from State	20b. PLACE	matory or a	of DISPO	SITION (Na	ame of		DA		CATION — CH			
	4 Donation 5 Othe	or (Specify).	state	cemetery, cre	o Cr						/13/9	4 Bal	t in	ore,	
	A Donetton S Other (Specify) State removal Crematory, INC. 12/13/94 Baltimore. M. State Anatomy Board Wade, Dir														
	Ronald Wade, Dir State Anatomy Board 655W. Baltimore St, Balto, MD 21201														
	IMMEDIATE CAUSE (Fi	naert fallure.	List only one ca	J G DQ	ull	not enter	Pe	all	ing, suc	h as car	aul	iratory arres	st,	Inter	
IFICATION	IMMEDIATE CAUSE (Fidisease or condition resulting in death) Sequentially list conditif any, leading to immicause. Enter UNDERLY CAUSE (Disease or Injusted events	itiona, ediete YING jury	a. Other to	G CONSE	DUENCEO	Per	Re W	ave	T Y	h as car	Faul	iretory erres	et,	Inter	
CERTIFICATION	IMMEDIATE CAUSE (Fidebase or condition resulting in death) Sequentially list condition any, leading to immicause, Enter UNDERLY CAUSE (Disease or in)	itiona, ediete YING jury	a. Other to	G CONSE	DUENCE O	Per	Re W	all all	TT	h as car	and lac or respiration	iretory errec	et,	Inten	
MEDICAL CERTIFI	IMMEDIATE CAUSE (Fidisease or condition resulting in death) Sequentially list conditif any, leading to immicause. Enter UNDERLY CAUSE (Disease or Injusted events	ittiona, edilete YING jury	a. Our TC	O ON AS A CONSE	DUENCE O	Pi: Pi: Pi:	Ke	are are	T y	+	24s. WAS AN PERFOI	AUTOPSY RMED?	2	WERE AUTO AMAILABLE F COMPLETION OF DEATH?	
MEDICAL CERTIFI	IMMEDIATE CAUSE (Fidisease or condition resulting in death) Sequentially list conditif any, leading to immicause. Enter UNDERLY CAUSE (Disease or Injusted intileted events resulting in death) LA: PART II. Other signific	itiona, edilete YING lury ST	a. Our TC	O ON AS A CONSE	DUENCE O	Pi: Pi: Pi:	Ke	are are	given in	Part I.	24a. WAS AN PERFOR	AUTOPSY RMED?	2	Approinters Onse WERE AUTOR AMAILABLE F COMPLETION OF DEATH? 1 YES 2	
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ED BY PHYSICIAN: MEDICAL CERTIFI	IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list condition and if any, leading to immediate. Enter UNDERLY CAUSE (Disease or inj that initieted events resulting in death) LA: PART II. Other signification and in the condition of th	itions, lediete YING jury ST	DUE TO HOSPITAL: 1 Inpetiant 2 26e. PLACE	D ON AS A CONSE	DUENCE O	OTHE 4 Number of July M	26. PP PR: raing Hom 20c. INV	g ceuse g	given in	Part I. eck only of the 26d, DB	24a. WAS AN PERFO! 1 YES 2	AUTOPSY RMED?	24b.	WERE AUTO AMAILABLE ICOMPLETIO OF DEATH? 1 YES	
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ETED BY PHYSICIAN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Fidebase or condition resulting in death) Sequentially list condition any, leading to immediate. Enter UNDERLY CAUSE (Disease or in) that initieted events resulting in death) LA: PART II. Other signification of the condition	itions, ediete ying lury ST Condition MEDICAL Pending Investigation Could not be dysermined RTIFYING PHYS	HOSTITAL: 1 Vinetal: 28e. PLACE 28e. PLACE building SICIAN: To the best of	D (OR AS A CONSECUTION OF INJURY — At ho, etc. (Specify)	DUENCE O DUENCE O DUENCE O DUENCE O DUENCE O DOLLAR	OTHE 4 Number of Survey Market for the ed at the	26. PPR: sling Horry office tory, office thine, date	g ceuse g	given in	Part I. B Oth 28t. LO Ch to the ca	24s. WAS AN PERFORM 1 YES 2 CATION (Street or or Town, State) RUBB(8) and mail	AUTOPSY IMED? I NO NUTRY OCCU and Number or	24b.	WERE AUTO AWAILABLE I COMPLETIO OF DEATH 1 YES	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	51	AIE UF M	AHYLAND	DEPAR CERTIF	ICATI	OF H E OF	EALTH DEAT	AND M 'H	ENTAL HYGI REG.				
	1. DECEDENT SAME	on caso 1	+	ELE		LEN C				2. DATE OF DEAT	ч	94 P	3. TIME OF DEATH G M M	
	4. SOCIAL SECURITY NUMBER 217-09-1195	5. SE	M 2 X F	6. AGE (In yrs.	lest birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign	
ОВ	9s. FACILITY NAME (If not institution 7 Belinda Avenue		d number)	•				nore C	OUNTY	гн		altimor		
ב	RESIDENCE OF DECEDI	COUNTY			10c CIT	Y, TOWN (OR LOCAT	ION					10d. INSIDE CITY	
E	Maryland	Baltim	are			.,			County	,		LIMITS?		
4	10e. STREET AND NUMBER							ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?			
ER/	7 Belinda Avenue)				21206						USA		
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Merri 3 Widowed 4 Divorced	ind F	AS DECEDENT ORCES? 1 [YES, GIVE WA	YES 2		1 3	It yes, spe	ENOENT O ecity Cuber 2 🖄 NO	, Mexicen,	ORIGIN? (Specit) Puerto Rican, atc.	Yes or No—	Black	— American Indian, , White, etc. White	
COMPLETED	15. DECEDEN (Specify only high Elementary/Secondary (0-12)	(Give kind of a life. Do NOT us	DENT'S USUAL OCCUPATION Isb. KIND OF BUSINESS/INOUSTRY Isb. KIND OF BUSINESS/INOUSTRY ISBWIIFE HOMEMAKING											
BE COM	17. FATHER'S NAME (First, Middle, Charles Rudolf H						E (First, Middle, Me te Seitz	iden Surneme)					
TO B	190. INFORMANT'S NAME (Type/P) Betty J. Wool						ute Number City or							
	20e METHOD OF DISPOSITION 1 Description Burlel 2 Cremation 3 4 Denetion 5 Other (Spec	Removal fr	om State		CEAND DATE				12-	0ATE 200		City or Ton		
	21. SIGNATURE OF FUNERAL SER	PVICE LICENSEE	veli	Yom's				ahn l	S OF FACIL	al Home d. Balt				
\dashv	23. PARTVI. Enter the disease				deeth, Do i								Approximata	
	ehock, or heert IMMEDIATE CAUSE (Finel disease or condition resulting in death)	fallure. List o	nly one ceus	se on each I	Ine.		,						interval Between Onset and Death HATS	
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events		DUE TO (OR AS A CON	SEOUENCE O	F):	c (CAI	RDIO	VASCU	lar.	disens	e syrs,	
CERT	resulting in deeth) LAST	d												
PHYSICIAN: MEDICAL	PART II. Other eignificent co	natoll		HATTA			nderlying	ceuee g	iven in Pa	PER	S AN AUTOPS	Y 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	
ä	DID TOBACCO USE (25. WAS CASE REFERRED TO ME		TE TO CAL				NO A	UNC	ERTAIN					
SC	EXAMINER?	HOS	SPITAL:		ACE OF DEAT	OTHE	₹:	-1-4	and I	Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pendi	. '	(Month, De	INJURY	28b. TIM		28c. INJU WOI	JRY AT	2	Bd. DESCRIBE HO	W INJURY C	CCURED		
TED BY	3 Suicide 8 Could		28e. PLACE OF building, s	INJURY — At itc. (Specify)	home, term, s	street, fect	ory, office		2	est. LOCATION (Str. City or Town, S		ber or Rural A	oute Number,	
COMPLETED										the ceuse(e) snd			and menner es stated.	
BE	29b. SIGNATURE AND TUTLE OF	В	Ara	W.	710	7		29c. LICE	NSE NUMB	112	29d. D	ATE SIGNED	(Monthy Day, Year)	
인	30, NAME AND ADDRESS OF PER	SON WHO COM	SHA	EOF DEATH (TEM 27) (Type	Print)	ROS	SSR	OAD	Dr. Ou)IN95	Milla	MD21117	
	31. OATE FILED (Month, Day, Year) DEC 13 1994	10	Tamelan.	Rendal			`				1-		7.	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

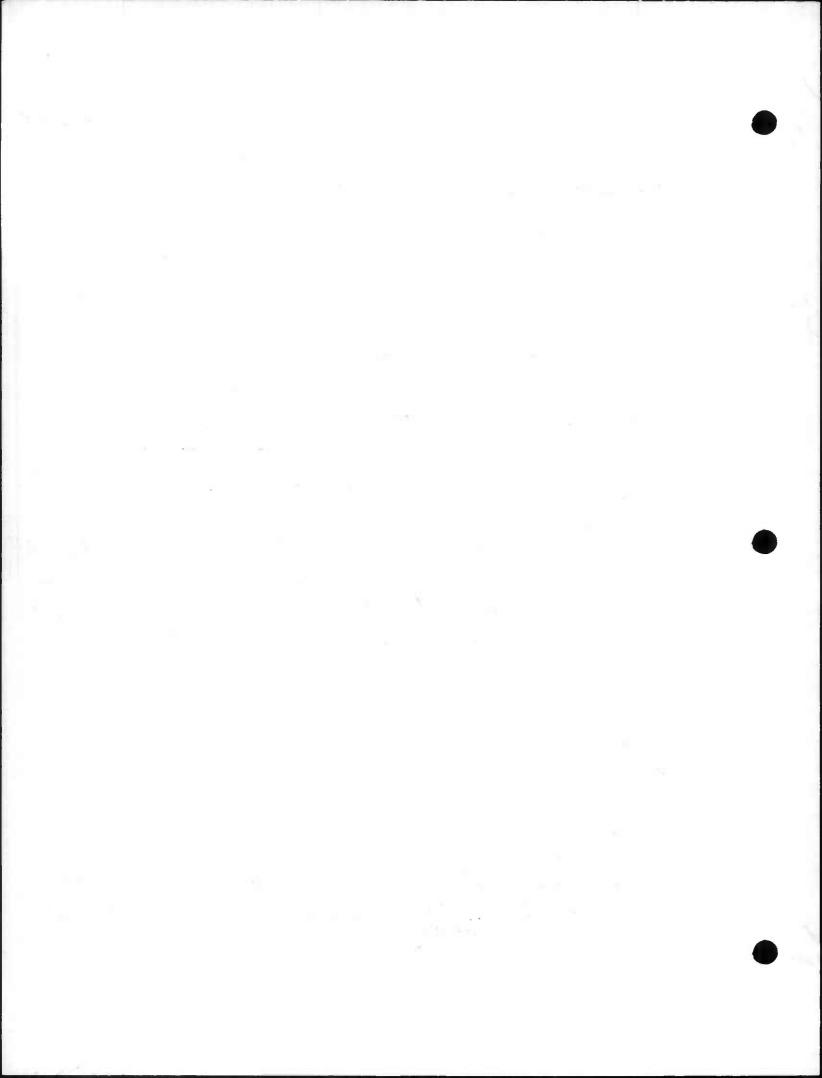
TO THE HOSPILL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

THE HOSPILL OR ATTENDING PHYSICIAN: The law requires that the death cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Jiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE OF	DEATH	REG. NO.						
1	t. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH				
	James H. Neill				Dec.10,	1004	TEAR MAY ALL				
		rs. last birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		. BIRTHPLACE (State or Foreign				
	217-05-7321 NOM2DF 80	The second second		HOURS MIN.	(Month, Day, Year)		Country)				
					7/12/1914 Maryland						
~	9e. FACILITY NAME (If not institution, give street and number)	91		OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
Ö	1734 Clarkson St.		Balto	o.City,	Md.						
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION 10d. INSID								
DIRECTOR							tod. INSIDE CITY				
	Maryland	Bal	to.Cit				XX YES 2 NO				
¥	10e. STREET AND NUMBER		10f.	ZIP CODE		C-1010	N OF WHAT COUNTRY?				
FUNERAL	1734 Clarkson St.			21230		Unit	ted States				
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.	S. ARMED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify			or No — 14	4. RACE — American Indian,				
- 11	1 Never Married 2 Merried FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE:			city Cubers, Mexican 2 🔯 NO Specify:	, Puerto Rican, etc.)		Specily: Tallhito				
B	2 Widowed 4 Divorced			X			Specify: White				
a B	15. DECEDENT'S EDUCATION (Specify anly highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY										
<u> </u>	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use re	c done during most etired.)	t of working							
4	8th.Grade	Laber	er		Chev	ron (Co.				
COMPLET	17. FATHER'S NAME (First, Middle, Last)	200702	1	18 MOTHED'S NAS	ME (First, Middle, Maiden :	-					
		1 1		Emma							
8	James Howard Neil			Jane	Wrot						
2	2200 300 300 300 300 300 300 300 300 300				oute Number, City or Town						
	Mr.James H.Neill				Balto.Md						
	t√E Buriel 2 ☐ Cremation 3 ☐ Removal from State cemeter	ACE AND DATE OF D	placel				ly or Town, State				
	4 Donation 5 Other (Specify) G16	en Have	n Mem,			en Bu	ırnie,Md.				
ŀ	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1	22. NAME AND ADDRESS OF FACILITY Balto. Md.								
	1/2 - 101 1/2-6	/	McCt	ıllv Fu	neral Ho	me.13	30 E.Fort Ave				
	23. PART I Enter the diseases or complications that maked the	e deeth. Do not		_							
	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate interval Between										
	IMMEDIATE CAUSE (Final	0	1				Onset and Death				
	disease or condition resulting in death)	return	Im	net			Jun 1.6				
- 1	DUE TO (OR AS A CO	NSEQUENCE OF		_	0 -						
z	T. Vreham	& bu	6	Kennel	d'aleve		1 alen				
	Sequentially list conditions, if eny, leading to immediate	MISE MEDICE OF):	11	70	1						
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	- State 1	text i	Their 1.	extrust (6. 1	12 W				
드	that initieted events	MISEQUENCE OF		, July		Lines					
ᇤ	resulting in death) LAST	doule.		0							
2	DART II Cab - I - Mi - A del	-									
DICAL	PART ii. Other significent conditions contributing to death but i	not resulting in t	he underlying	ceuse given in I	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
8 1					1 YES 2	□ NO	COMPLETION OF CAUSE OF DEATH?				
ME							1 YES 2 NO				
					_						
¥	25. WAS CASE REFERRED TO MEDICAL		26. PL/	ICE OF DEATH (Che	ck only one)						
PHYSICIAN:	EXAMINER? t YES 2 NO		THER:								
žΙ	27. MANNER OF DEATH 28e. DATE OF INJURY	26b. TIME O		5 Residence	28d. DESCRIBE HOW IN	I IIIIV OCCUI	DED.				
	1 Metural 5 Deadles (Month, Day, Year)	INJUR	Y WOR	IK?	200. DESCRIBE NOW III	AJUNT OCCUP	NED .				
B	2 Accident Investigation			ES 2 NO							
	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — building, etc. (Specify)	At homa, farm, stre-	et, tectory, office		281. LOCATION (Street e City or Town, State)	nd Number or	Rural Route Number,				
COMPLETED	- Tomote Getermine										
7	29a. CERTIFIER (Check only t CERTIFYING PHYSICIAN: To the best of my knowledge	je, death occurred a	it the time, date o	end place, end due	to the cause(e) end man	ner se stated.					
NO.	one) 2 MEDICAL EXAMINER: Dn the basic of examination en										
	29b. SIGNATURE AND TITLE OF CENTIFIER		T-								
H	R 01 11- 1 40			29c. LICENSE NUM	7	29d. DATE S	SIGNED (Month, Day, Year)				
2	30 NAME AND ADDRESS OF REDSON THIS COURT THE AND ADDRESS OF REDSON THIS COURT THE AND ADDRESS OF REDSON THIS COURT THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF REDSON THE ADDRESS OF THE AD	/ITEM OF /		11039		-12	112/77				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH					1	1112				
	BEAMAND 3. KARDEAS J	r. mo	101W.	READS	i- Kuion	MACTO	MO 21201				
	DECT 3 1994 July Drugger And State Charles	34									
	DEOT 0 1994	•									



Item#10a,17,18 Per F.H. Film#G-718 12/13/94 R.M.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH (2) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Qay, Year IF UNDER 1 YEAR IF UNDER 24 HRS. AUG. 31, 762 DAYS HOURS NIGERIA (ONITSHA 1 M 2 F 1959 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 CHURCH HOME HOSPITAL BALTIMORE CITY n/a RESIDENCE OF DECEDENT MARY LAD 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE n/a YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES n/a funeral director, page 5 should be detached for use as the burial-transit unknown 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married Specify: BLACK 1 TES 2X NO BY Specify. 3 Widowed 4 Divorced AFRICAN COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade comple 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Etementary/Secondary (0-12) College (1-4 or 5+) STUDENT/LABORER n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) unknown BENEDICT OKADIGBO unknown ROSE OKADIGBO retained by BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Str 2 AVENUE, BALTIMORE, MARYLAND 21214 MARY LOUISE ZOLLARS 3009 WHITE ours after death. Page 6 may be be 20a. METHOD OF DISPOSITION

1 Mariel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must SACRED OF HEART 4 Donation 5 Other (Specify) CEMETERY 12-14 BALTIMORE co, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. c. MARCH FH.-1101 E. NORTH AVENUE filled in by the fu medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Final** n and completely filled to burial, cremation, o the disease or condition rais event. resulting in desth) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if sny, lasding to Immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to certificate be other CAUSE (Disesse or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO COMPLETION DF CAUSE OF GEATH? 30 any Signed 1 1 YES 2 NO shows 1 YES 2 NO has been s PHYSICIAN: . DR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bhours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate in the State HOSPITAL: OTHER: 1 ☐ YES 2 ☐ NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) .60 6 Could not be COMPLETED 4 Homicide 28 Hem 29a. CERTIFIER

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(C HOSPITAL ((Check only one) TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data end place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29C, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE AR Cevario MI 8 uci alist 40356 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print, 10 AN ARRO 2123 0 Troadway

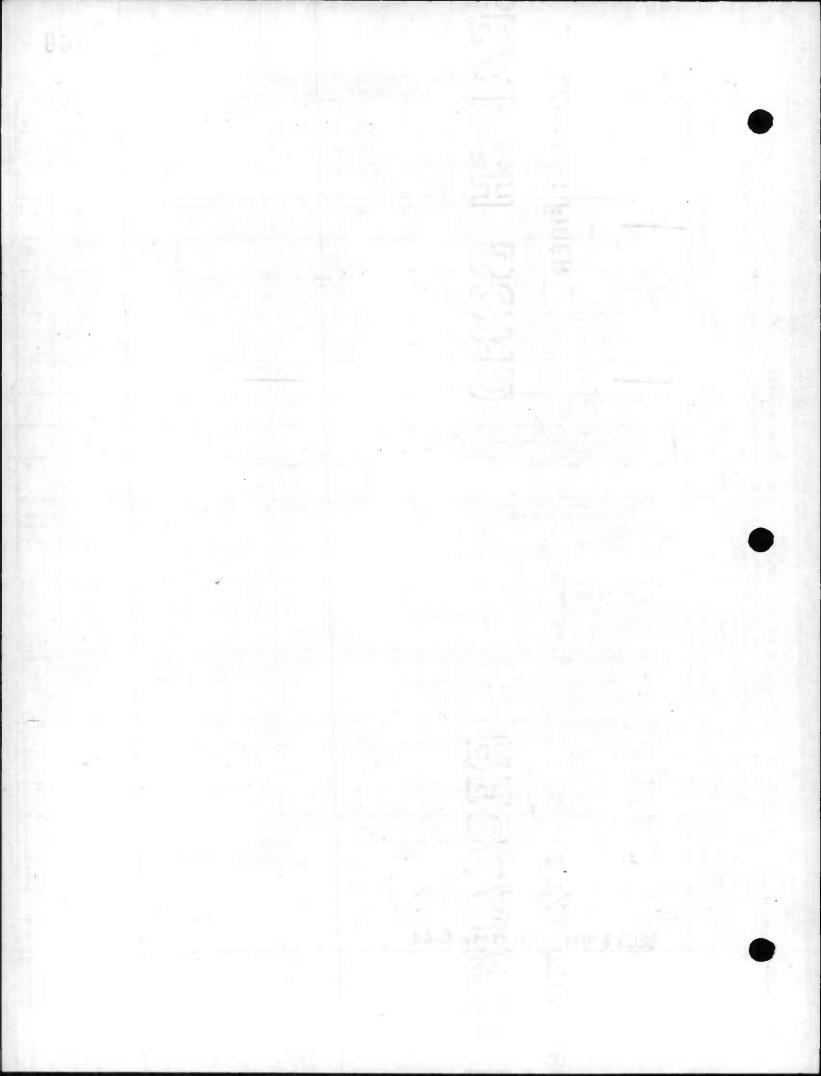
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31. DATE FILEO (Month, Day, Year)

3 1994

32. REGISTRAR'S SIGNA

lia Naveleon Randall



94-7209-510 ITEM: 7. PER F.H. FILM G-718 12/27/94 t.t

2/13/94 t.t

<u>B</u> lh	ITEM:						
STATE	STAT	E OF	MAR	YLAND	/ DEF	PARTME	T

1 - STATE REGISTRAR	SIAIE UF MARY	CERTIF	CATE				MENTAL	REG. NO.	E			
1. OECEOENT'S NAME (First, Middle, Last)								F DEATH			3. TIME OF DEATH	
Mildred	Ρ.	Ohlve	x+ox				MONTH	_ 1 1		YEAR Q Q /	0.4.0.0 M	
	. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1	_	IF UNDER		NOV.	FBIRTH	1	8. BIRTI	IPLACE (State or Foreign	
213-52-3483 '	□ M 2 ▼ F	51 YRS.	MONTHS	DAYS	HOURS	MIN.	Oct.	25/1	943	Ma	ryland	
9a. FACILITY NAME (If not institution, give street	t and number)		9b. CITY, 1	TOWN OF	LOCATIO	ON OF DE			9c. COUNTY OF DEATH			
1277 BATTERY	Avenue		Baltimore City									
RESIDENCE OF DECEDENT		I man										
		10c. CI	TY, TOWN OR			MA	1				10d. INSIDE CITY LIMITS?	
Maryland			Balto.City,Md								1 X YES 2 NO	
	ttery Av	e.	21230							zen of what country? ced States		
	S 2 JHO					NC ORIGIN?		or No-	14. RACI	E — American Indian, k, White, etc.		
1 Never Married 2 Married 3 Widowed 4 Divorced	2 NO		n, Puerto Ric y:	cen, atc.)		Spec						
15. DECEDENT'S EDUCATI (Specify only highest grade con	ION	18a. DECEDENT'S	USUAL OCC	UPATION	N .		16b. F	(IND OF BUS	SINESS/IN	DUSTRY		
Elementary/Secondary (0-12)	life. Do NOT u	work done du ise retired.)	ring most	of workin	g	1						
3rd.Grade -	Ne	one				D	isab	led				
17. FATHER'S NAME (First, Middle, Lest)				18. MOTH	IER'S NA	ME (First, Mic	ddle, Maiden	Surname)				
Unkno	Cormick				Ţ	Jnkno	wn					
19a. INFORMANT'S NAME (Type/Print)			AOORESS							Code)		
Mr.Robert Ohlve	rter	127	7 Bat	ter	y P	ve.	Balt	o.Md	. 2	1236)	
20e. METHOD OF DISPOSITION 1 1 2 Burlel 2 Cremation 3 Removal	I from State	0b. PLACE AND DATE	OF DISPOSIT	ION (Nem	ne of		DATE	20c. LO	CATION -	-		
4 Donetion 5 Other (Specify)		cedar H						A	A/A.Co.Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENS	1 /	/	22. NAME AND ADDRESS OF FACILITY Balto.Md. 212.								1. 21230	
Hany a	- Mario	7	Mo	:Cu]	lly	Fun	neral	Hom	e,13	30 E	Fort Ave	
23. PART i. Enter the diseases, or com	plicetione that caus	ed the death. Do	not enter ti	he mod	e of dyl	ng, aucl	h aa cerdia	c or reepi	ratory er	reat,	Approximate	
ahock, or heart fellure. List iMMEDIATE CAUSE (Finel	t only one cause on	eech line.			«	1				Non	Interval Between Onset end Death	
disease or condition resulting in death)	Hunz Bus	are Atra	weck	est.	21	Carl	P- 1300	cu Par	An	0 1		
	DUE TO (OR AS	A CONSEQUENCE O	OF):			C 420	1000		1 612			
Sequentielly list conditions, b.												
if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	IF):									
CAUSE (Disease or injury	DUE TO 100 AS	A CONSEQUENCE O									-	
thet initiated events reaulting in death) LAST	DUE TO (OH AS	A CONSEQUENCE O	r-):									
d												
PART II. Other eignificant conditions c	ontributing to death	but not resulting	in the und	erlying	cause g	iven in	Part i. 2	4s. WAS AN		24b	WERE AUTOPSY FINDINGS	
							_ ,	PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE	
								7	-		OF DEATH?	
DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEATH Y	ES N	0 🗆	UNC	ERTAIN	<u> </u>				_	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF OEA		ly one)								
The second secon	OSPITAL: Inputient 2 ER/O	rtpatient 3 🗆 DOA	OTHER:	g Homa	5X XRes	sidenca	6 Other (Specify)				
27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year,		IE OF 2	8c. INJUI WOR			28d. OEŞÇI	RIBE HOW I	NJURY OC	CURED		
1 Natural 5 Pending 2 Accident Investigation			М	1 YE		NO NO						
3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUI building, etc. (Sr	RY — At home, ferm, secily)	straat, 1ector	y, office			281. LOCAT City or	ION (Street a Town, State)	nd Number	or Rural F	Route Number,	
29a. CERTIFIER	I. To the heart of the second			107-05					2 (4.5) 22102	201		
(Check only one) 1 CERTIFYING PHYSICIAN MEDICAL EXAMINER: 0												
	The second of examination	show mireshy in	on, m my opi	-				nu piace, an	u due 10 1h	e cause(a) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER	1/	0			29c. LICE	NSE NUM	IBER		29d. OAT	E SIGNED	(Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO	MELETED CAPIES OF	c i)	Dela **		0.	C.M	F		De	c 1	1 1994	
THENDORE MIL	King			Str	ceet	. B	alti	more	. Ma	rvl	and 21201	
31. DATE FILED (Morith, Day, Year) DECT 3 1994 July	32. REGISTRAR'S SIG	ardall							, ,,,,	<u>y</u> _L	CICUI	

IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR

1 -

REG. NO

permit. funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 signed by the attending physician and completely filled in by the theatth and Mental Hygiene prior to burial, cremation, or removal. HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760, this certificate h

1. OECEDENT'S NAME (First Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SX Annie SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF WHOER I YEAR a. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 7. DATE OF BIRTH MAY 1, 1914 215-24-9413 80 DAYS 1 M 2 XX YRS. CAROLINA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH n/a BALTIMOEE CITY **JOSEPH** RITCHIE HOSPICE DIRECTOR RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY n/a BALTIMORE MARYLAND 1 YES 2 NO 10- STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21213 UNITED STATES 1114 N. KENWOOD **AVENUE** 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.; 1 TES 2 NO Specify Specif BLACK BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION sectly only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 11 TH DOMESTIC n/a 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) TE JAMES Α. MC MILLAN MARY **JONES** Ε. BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 OAKS AVE, PETERSBURG, VIRGINIA 23805 LACY 2534 MERRY MC MILLIAN pe 20a. METHOD OF DISPOSITION
1 ∑ Burlat 2 □ Cremation 3 □ Ramoval from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify) MF MORTAL RAM RANDALLSTOWN, MD PARK 12-14 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Beman WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART I. Entar the diseases, by complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the diseese or condition RESPIRATORY DUE TO (OR AS A CONSEQUENCE OF): resulting in death) MINUTES event. APRIAC ARREST traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury BRAIN TUMOR or other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL shows any COMPLETION OF CAUSE I TYES 2 NO OF DEATH? 1 | YES 2 | NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Realdence 6 ★ Other (Specify) 1 TYES 2 T NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA J. RICHES 10 HOSPICE 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 2Sc. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. (Month, Day, Year) 2/8/44 1 Natural 5 Pending 5:30 PM 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 28a. PLACE OF INJURY — Al homa, farm, atreet, factory, offica building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 50 6 Could not be COMPLETED 4 Homicide 28 datarmined Item 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIRE WITHIN 72 ho (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29h. SIGNATUBE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BALTIMORE mes CHASE 31. DATE FILED (Month

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

10.46

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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VSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 may be retained by the hospital or att	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shou	te De	28 is marked, or item 23 shows any Injury or other traumatic event, the medical examiner must be notified at once
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) KATHLEEN ANNE PA	ULUS				2. DATE OF DEATH		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 518-30-4417		· · · · · ·	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH Sept. 25,	1931 Id	HPLACE (State or Foreign aho
5	9a. FACILITY NAME (If not institution, give s Stella Maris	street and number)		96. CITY, TOWN O	PR LOCATION OF DE	EATH	Balti	
	10a. STATE 10b. COUNT Maryland Har	ford	10c. CITY,	TOWN OR LOCAT	Belca	mp		10d. INSIDE CITY LIMITS?
FUNERAL DIRECTOR	100. STREET AND NUMBER 4326 Gilmer C	ourt		101	ZIP CODE 210		10g. CITIZEN OF	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 NO	If yes, sp		NIC ORIGIN? (Specify Yea in, Puarto Rican, etc.) y:	Blac	CE — American Indian, ck, Whita, atc.
COMPLEIED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2 t h	JCATION e completed) College (1-4 or 5+)	16a. DECEDENT'S U (Give kind of we life. Do NOT use Maid	ork done during mo		Domost i		ing Business
	17. FATHER'S NAME (First, Middle, Last)	Edward Her		sley	16. MOTHER'S NA	ME (First, Middle, Maiden Mary Ida	Surname)	
IO BE	19a, INFORMANT'S NAME (Type/Print) Mary Lynn Cha	se				Aoute Number, City or Town Belcamp,		017
	20a. METHOD OF DISPOSITION 1	noval from Stata	PLACE AND DATE OF	Matory	, Inc.	12/12/94 Ba	cation — city or 1 altimor	e, MD
	21. SIGNATORE OF FUNERAL SERVICE LI	NICHOY	raid.	299 1	rederi	ck Rd. Ba	altimor	and, Inc. e, MD 21228
	23. PART I. Enter the diseases, prahock, prheart fellure. IMMEDIATE CAUSE (Finel disease pr condition resulting in death)	e. BRANT	ech line.		de of dying, suc	h as cerdiac or reepi	ratory arrest,	Approximate interval Between Onset and Death
MILLICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST	b. DUE TO (OR AS A	A CONSEQUENCE OF)		JENOU	N PRIM	ARN	linknom
EDICAL C	PART II. Other algnificent condition	s contributing to death b	out not resulting in	the underlying	ceuse given in	Pert I. 24a. WAS AN PERFOR 1 □ YES 2	MED?	b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN: M	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CAUSE OF		ES NO			
JETHT I	1 Yes 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	HOSPITAL: 1 Inpatient 2 ER/Outs 26a. DATE OF INJURY (Month, Day, Year)		OF 28c, INJ		6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED	
200	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ferm, sti	reet, factory, offic		28f. LOCATION (Street a City or Town, State)	nd Number or Rurel	Floute Number,
CIMIC		CICIAN: To the best of my know ER: On the basis of axamination						(a) and manner as stated.
0 0 0	296. SIGNATURE AND TITLE OF CERTIFIE COCOLOR 20 NAME AND ADDRESS OF BERSON WILLIAMS	Faulkne			D D 5 C	MBER 043	29d. DATE SIGNE	O (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO DR. KENDALL FAULK	NER 2300 DU	LANEY VAI		D TOWSO	ON, MD 2120)4	
	31. DECT 3 1994 J	all a hucker has	Zall					



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BALTIMORE, MARYLAND 21215-0020

PIVISION OF VITAL RECORDS, P.O. BOX 68760,

MAINTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

UNECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

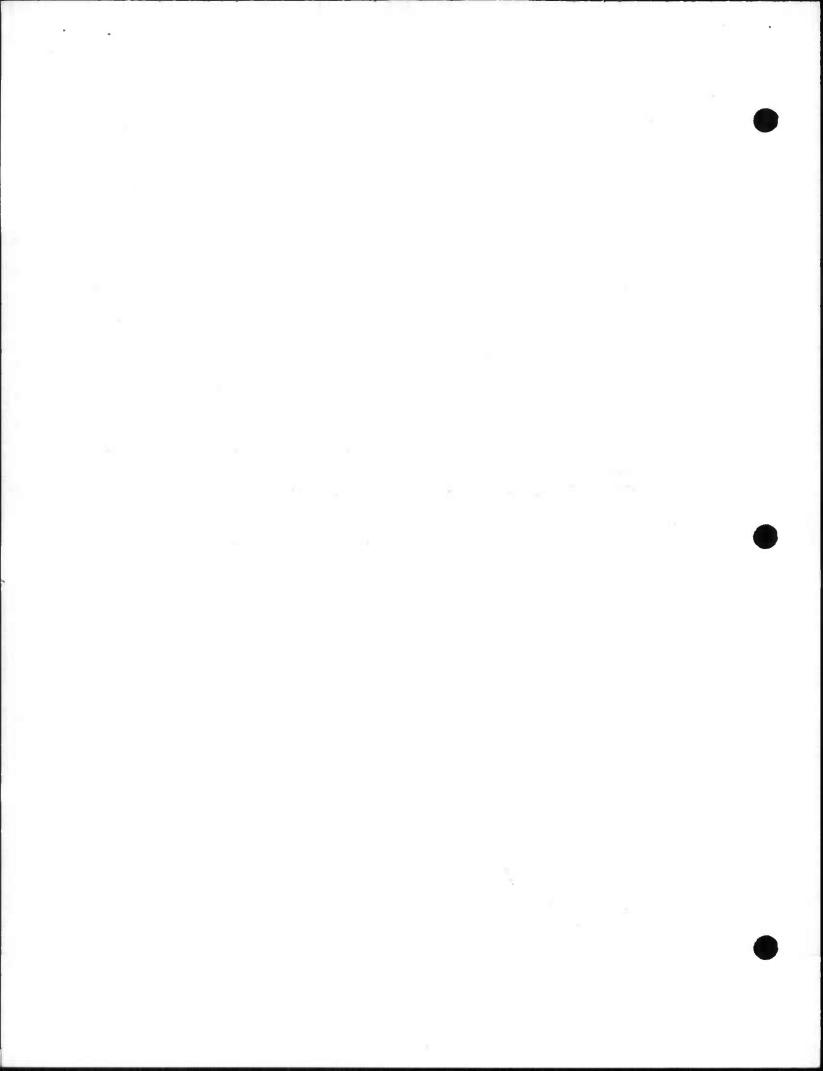
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIFIC	ATE O	F DEATH	A	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) MICHAEL	E.	PETT	т.			2. DATE OF E	DEATH DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER								1994	6:05 a. м
1	158-18-1276	1 🗙 M 2 🗆 F	AGE (In yrs. las		DNTHS DAY		7. DATE OF B (Month, Day May 13	1926	Count	HPLACE (State or Foreign try) ISylvania
~	9a. FACILITY NAME (If not institution, give si	,		9		N OR LOCATION OF D		9c. CO	UNTY OF E	DEATH
5	THE JOHNS HOPKI	NS HOSPITA	1 L		BALT.	MORE CIT	Υ			
REC	10a. STATE 10b. COUNTY	r		10c. CITY, 1	TOWN OR LO	CATION				10d, INSIDE CITY LIMITS?
ā		ddlesex		P	ort Re					1X YES 2 □ NO
FUNERAL DIRECTOR	100. STREET AND NUMBER 142 First Ave.					101. ZIP CODE 07064	1	10g. CI	TIZEN OF Y	WHAT COUNTRY?
5	11. MARITAL STATUS 1 Never Married 2 K Married	12. WAS DECEDENT E FORCES? 1 V IF YES, GIVE WAR	VER IN U.S. AR	MED IO	13. WAS E	ECENDENT OF HISPA specify Cuben, Maxic	NIC ORIGIN? (Sp	pecify Yea or No-	14. RAC	E — American Indian,
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES WW II			ES 2 NO Specif		,,	Spec	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(G/	CEDENT'S US ive kind of work Do NOT use n	k done during	TION most of working	16b. KINI	D OF BUSINESS/IN	DUSTRY	
APLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		vice :		cian	F	ood Serv	vice	
00	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle	, Malden Surname)		
BE	Peter Petti	·					ed Iann			
2	190. INFORMANT'S NAME (Type/Print) Elizabeth Petti					ve., Port				. 4
	20a. METHOD OF DISPOSITION		20b. PLACE	ND DATE OF	DISPOSITION	Name of	DATE	20c. LOCATION -	0706	
	1 Burlel 2 Cremation 3 X Rame 4 Donation 5 Other (Specify)	oval from State	cametery, cree	rleaf	Memor	ial Park	12/13	Woodbri		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				AND ADDRESS OF FA	CILITY			
	H. Gene	alle	2		6009	Harford	Rd., B	altimore	e, MD	21214
	23. ART i. Entar the diseases, proshock, pr heart failure.	empilcations that c	gueed tha de	ath. Do not	enter tha	node of dying, aud	ch as cerdiac	or respiratory s	rrest,	Approximsta intervsi Between
	MMEDIATE CAUSE (Finei disease or condition									Onset and Death
	resulting in death)	DUE TO (0)	AS A CONSEC	DUENCE OF):						3 hours
N	Sequentisily list conditions,	Klat	Skin	cholo	angi	ocarcin	oma			2 months
CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OI	R AS A CONSEC	DUENCE OF):	0					
띮	CAUSE (Disease or Injury that initisted events	DUE TO (OI	R AS A CONSEC	DUENCE OF):						
ERT	resulting in desth) LAST	d								
	PART II. Other significant condition	s contributing to de	eth but not re	esuiting in	the undarly	ing cause given in	Pert i. 24a.	. WAS AN AUTOPSY	241	o. WERE AUTOPSY FINDINGS
DICAL	Renal fail						~	PERFORMED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
								123 1 110		OF DEATH?
PHYSICIAN: ME	DID TOBACCO USE CONTE	RIBUTE TO CAUS	SE OF DEA	TH YES	□ NO	UNCERTAI	N 🗆			/
S C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			THER:					
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 N Inpatient 2 E	JURY	28b. TIME D	F 28c. I	ome 5 Realdence		E HOW INJURY OF	CCURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	INJUR	Υ	YORK? YES 2 NO			JOUNED	
	3 Suicide 8 Could not be determined	28e. PLACE OF II building, ato	NJURY — At hor . (Specify)	me, ferm, stre	et, factory, of	fice	281. LOCATION City or Tov	N (Street and Number vn, State)	er or Rural I	Route Number,
P.E.	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my	knowledge, der	ath occurred a	it the time, d	its and place, end due	to the cause(a)	and menner as at	ated.	
COMPLETED	one) 2 MEDICAL EXAMINE									s) end manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	2				29c. LICENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Year)
2	J Mada J.	jui	MD	4 am .r.		1 M37	24		2/1	0/94
•	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	- MO			AU HS Ta	VER 110	Johns Ho	phasi	Hospital
	DEC1 3 1994	di Diwelson	Rarbally							

1 - FOR STATE REGISTRAR

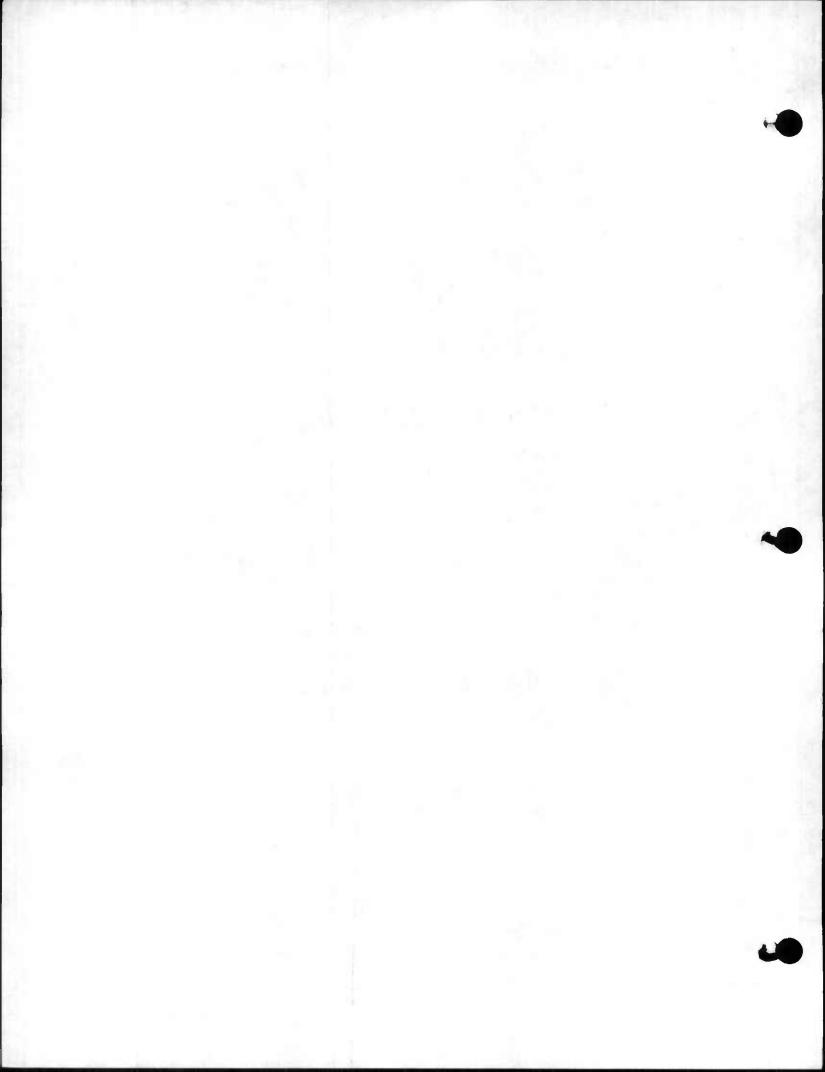
											TIEG. NO.			
										2. DATE OF MONTH			YEAR	3. TIME OF DEATH
										Dec.	8	3, 19	94	9:45 PM
						-		-		(Month, L	Day, Year)			PLACE (State or Foreign
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-										ATH				
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E C	10a. STATE		Υ		10c. CIT	ry, TOWN	OR LOCA	TION						10d. INSIDE CITY
8	Maryland	Balt	imore		- 1									LIMITS?
	10e. STREET AND NUMBER					3			E			10a, CITIZ	ZEN OF V	
ER	814 Petem F	Road						210	087					
3	11. MARITAL STATUS		12. WAS DECEDER	NT EVER IN U.S.	ARMED	13.	WAS DE	CENDENT C	OF HISPANI	C ORIGIN?	Specify Yas	or No—	14. RACE	E — American Indian.
			IF YES, GIVE	1 ∐ YES 2 (WAR OR DATES	Дио						en, etc.)			k, White, etc.
	3 X XWIdowed 4 Dive	erced				}								ite
	15. DEC (Specify onl)	EDENT'S EDU y highest grade	CATION completed)	16a.	(Give kind of	work done	during me		ng	18b. K	IND OF BUS	INESS/IND	USTRY	
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	1 N Burlel 2 L Cremetic	n 3 🗆 Rem	oval from Stafa	cemetery.	crematory or o	of DISPO	SITION (N	ame of	- 40/	DATE	20c. LO	CATION — C	Olty or To	wn, Stata
			CENSEE 🔿	- [High	view	Memo:	rial	UTO:	S.12/	12/94	<u>ң</u> ғат.	Iston	,Mai	ryland
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	6.6	J.C	Tasi	rakk										ld.21087
	23. PART I. Enter the d	iseases, or o	complications the	at caused the	death. Do	not enter	the mo	ode ot dy	ing, such	as cardia	c or respi	ratory arre	eat,	Approximate interval Between
		and a	•									1.5		Onset and Deal
	disease or condition reaulting in death)	→	a. A 4	there	501	ero	tic	Ca	Jd10	Vasa	lar	dis	seas	e years
			DUE TO	OR AS A CON	SEOUENCE C	F):								1
2	Sequentially jist condit	ions.	b											
Ě	if any, leading to imme	diate	DUE TO	OR AS A CON	SEQUENCE O	F):								
윤	CAUSE (Disease or inju		c. DUE TO	OR AS A CON	SEQUENCE O	e.								
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CIA	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	28. PL	ACE OF DEA									
YSI	1 TYES 2 NO			☐ ER/Outpatient	3 DOA			ne 5 🗆 Re	esidence 6	Other (S	Specify)			
H H	M _	Dandina			28b. TIN	IE OF JURY	28c. IN. WC	JURY AT DRK?		28d. DESCF	IBE HOW IN	JURY OCC	URED	
BY						М] NO					
			28a. PLACE C building,	OF INJURY — At , etc. (Specify)	home, tarm,	streat, fac	tory, offic	in .				nd Number	or Rurel F	loute Number,
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뒬	(Check only													
Š	2 MEDI	CAL EXAMINE	R: On the basis of a	xamination and/	or investigation	on, in my	opinion, c	leath occur	red at the ti	lme, data an	d placa, and	d due to the	cause(s) and manner as stated.
ш	29b. SIGNATURE AND TITLE	OF CERTIFIER	01					29c. LICE	ENSE NUME	BER	Ĭ	29d. DATE	SIGNED	(Month, Day, Year)
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F	44 1.	PERSON YH	O COMPLETED CAU		0 /3		Λ	. (1.	1	1 /	2	- 6	
	Mark	W. 10	4 2	NETT	h /4	ve	13	21,	1+11	10	d	210	14	
	31. DATE FEET VAPINITIES	194 9	32. AEGISTR	AR'S SONATURE	1									
	COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO B	ROSALINA MA 4. SOCIAL SECURITY NUMBE 218-12-2513 90. FACILITY NAME (# not in Bel Forest RESIDENCE OF DEC 100. STATE MARY Land 100. STATE MARY LAND NUMBER 814 Petem Film Mary Land 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARY Mary Land 12. STATE MARY (First. M Vincent Imb. Stephen B. 20. METHOD OF DISPOSIT IN Burlel 2 Crematk Land Donation 5 Other Land Land Land Land Land Land Land Land	4. SOCIAL SECURITY NUMBER 218-12-2511 9e. FACILITY NAME (If not institution, give is Bel Forest Nursing Residence of Decedent 100. Count Maryland Balt: 10e. STATE 10b. COUNT Maryland Balt: 10e. STREET AND NUMBER 814 Petem Road 11. MARITAL STATUS 1 Never Married 2 Married 3 XXMIdowed 4 Divorced 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 7th. 17. FATHER'S NAME (First, Middle, Last) Vincent Imbragug. 19e. INFORMANT'S NAME (Type/Print) Stephen B. Prover 20e. METHOD of DISPOSITION 1 Suriel 2 Cremetion 3 Rem 4 Donetton 5 Other (Specify) 1. SIGNATURE OF FUNERAL BERNICE LIST (Secondary in death) 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) 23. PART II. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) 24. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Obsesse or injury that initiated events resulting in death) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Sulcida 6 Could not be determined determined determined determined determined and medical conditions in the middle of Could not be determined determined and medical cause. Examiner 1 Medical Examine 200. NAME AND ADDRESS OF PERSON YANDERS OF PERSON YAN	Rosalina Mary Provenza 4. Social Security Number 2. Sex 218-12-2511 9e. FACILITY NAME (If not institution, give street and number) Bel Forest Nursing Home Residence of Decedent 10e. STATE 10e. COUNTY Maryland 11. Marital Status 12. Was Decedent 13. Wildowed 1 Divorced 15. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) Vincent Imbraguglio 18. Informant's Name (Typa/Print) Stephen B. Provenza, Sr. 20e. Method of Disposition 18. Surial 2 Cremelion 3 Removal from Stafe 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUHERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one can immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) DUE TO CAUSE (Disease or injury that initiated events resulting in death) Last DID TOBACCO USE CONTRIBUTE TO CAUSE (Check only one) 25. Was Case reference to Medical Examiner: on the basis of the Monte of Death Investigation 27. Manner of Death 1 Monters of Death 1 Monters of Death 1 Monters of Death 29e. Certifier 29e. Certifier 29e. Signature and title or certifier 30. Name and address of person who completed cause. Endowed and the determined death of the basis of the monter of the basis of the original contribution of the death of the original contribution of the determined determined death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the death of the original contribution of the original contribution of the original contribution of the original contribution	ROSALINA MARY PROVENZA 4. SOCIAL SECUNTY NUMBER 218-12-2511 9e. FACILITY NUMBER 218-12-2511 9e. FACILITY NUMBER 218-12-2511 9e. FACILITY NUMBER 3 SEX 3	ROSALINA MATY PROVENZA 4. SOCIAL SECURITY NUMBER 218-12-2511 1	ROSALINA MARTY PROVENZA 4. SOCIAL SECURITY NUMBER 218-12-2511 10	ROSALINA MATY PROVENZA 4. SOCIAL SECURITY NUMBER 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SEK 218-12-2511 5. SECLITY NAME (if to distribution), pive sized and runchos) 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Home Fore Maryland 8el Forest Nursing Fore Road 11. Mayrla Status 100. State 11. Was December 100. Control 11. Mayrla Status 12. Was December 100. 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SETTER SECURITY MARKE (or or introduct, one street and number) 8. SECURITY MARKE (or introduct) 8. SECU

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



VOID CERTIFICATE ** 94-36774 SEE CERTIFICATE ** 94-00320

FETAL DEATH



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

213-36-6705

4. SOCIAL SECURITY NUMBER

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permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH HARBOR HOSPITAL CENTER BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION Maryland Baltimore Co Baltimore FUNERAL 10a, STREET AND NUMBER 10f ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 419 Cresswell Road 21225 urs after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify No BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker 17. FATHER'S NAME (First, Middle, Last) Otto H. Feldman to BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Mrs Barbara Stankiewic 420 e 20a. METHOD OF OISPOSITION
1 Buriet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir examiner and completely filled in by the burial, cremation, or removal. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, shock, or heart failure. List pnly one ceuse on each line IMMEDIATE CAUSE (Final the disease or condition resulting in death) Cardiomyopathy ischemmic event. DUE TO (OR AS A CONSEQUENCE OF): Acute interior traumatic myocardi CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to if sny, lasding to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING artery CAUSE (Disease or injury other that initiated events resulting in death) LAST 10 any injury. PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL signed by the has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h with the State I HOSPITAL: OTHER 1 % Inpetient 2 - ER/Outpetient 3 - DOA 1 | YES 2 | 16 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? is marked, INJURY Natural 1 YES 2 NO BY After _ Accident 28a. PLACE OF INJURY — Al home, farm, street, factory, office building, alc. (Specify) 3 Suicida 8 Could not be determined COMPLETED DIRECTOR: after 28 4 Homicide NOURS B 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL IN TO THE FUNERAL ED Be filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGHATURE AND TITLE OF CERTIFIER 29¢ LICENSE NUMBER BE Laballero 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3001 S. HANOUER ST., BALTHORE, MD ABALLENO, YURI. 32 REGISTRAR'S SIGNATURE Stwelson Rardall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

IF UNDER 1 YEAR

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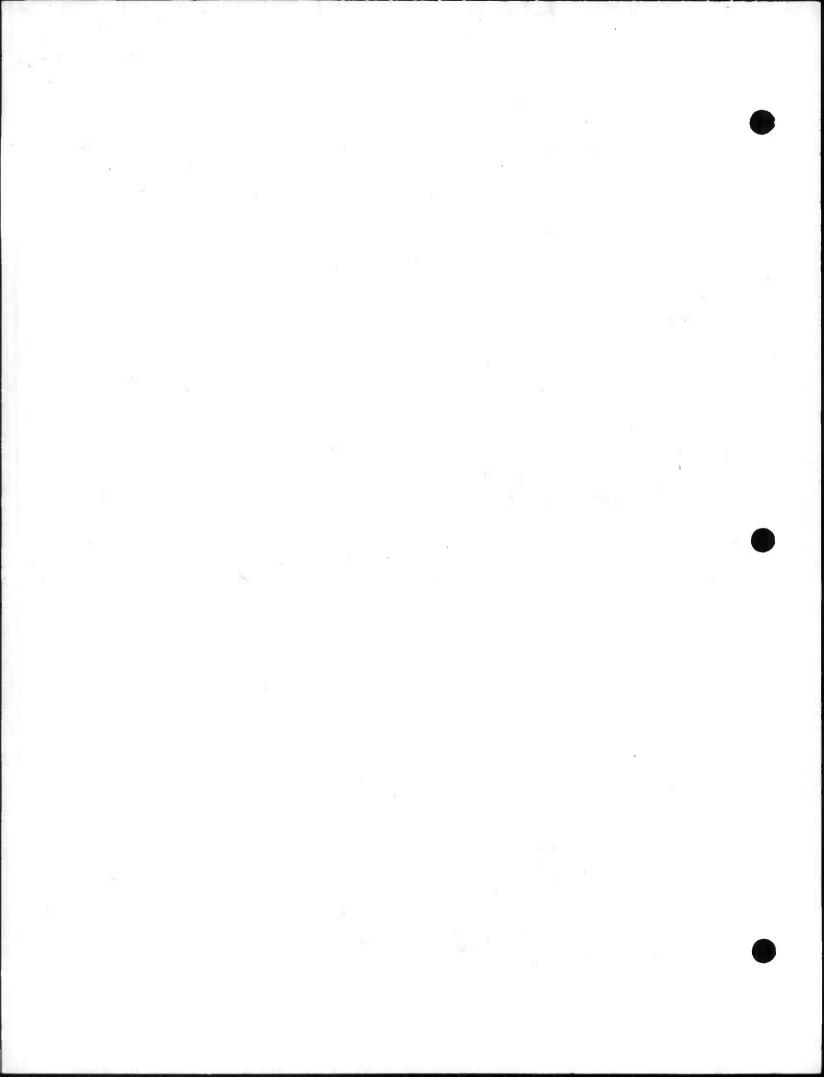
6. AGE (In yrs. leat birthday)

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5. SEX

1 M 2 X F

CERTIFICATE OF DEATH 2. DATE OF DEATH 3. TIME OF DEATH MONTH 2 6.28 BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH IF UNDER 24 HRS. (Month 31 Marvland 9c. COUNTY OF OEATH BACTINO DE 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 13. WAS OCCENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY SweetHeartCupFactory 18. MOTHER'S NAME (First, Middle, Malden Surname) Pauline Eugene Cherry St. Baltimore, MD21226 20c. LOCATION — City or Town, State DATE 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.BaltimoreSt,Balto,MD21201 Approximata Interval Batween Onset and Desth 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month), Day, Year)



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TO THE HOSPITAL DRIVING PHYSICIAN: The law requires that the death certificate be executed within a flour after death. Page 6 may be retained by the hosp TO THE FUNERAL LACETOR As this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours. The formal thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - STATE REGISTRAR	STATE OF MARYI		MENT OF H		MENTA	L HYGIEN	_		
Manage Ma	1. DECEDENT'S NAME (First, Middle, Lest) JOSEPHINE S	RUBEI				MONT	OF DEATH	AY	YEAR	TIME OF DEATH
R	4. SOCIAL SECURITY NUMBER 5	SEX 6. AGE M 2 K F t and number)	(In yrs. lest birthday) P6 YRS.		IF UNDER 24 HRS. HOURS MIN. PR LOCATION OF D	7. DATE (Mont Feb	OF BIRTH th, Day, Year) . 8, 1	898 9c. COUN	8. BIRTHPI Country)	ACE (State or Foreign Italy
AL DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	ltimore	10c. CITY,	Timor	ION	<u> </u>				04. INSIDE CITY LIMITS? YES 2 NO AT COUNTRY?
BY FUNERAL	13 Roundridge Rd 11. MARITAL STATUS 1	2. WAS DECEDENT EVER FORCES? 1 YES	2 NO	If yes, sp	21093 ENDENT OF HISPA	an, Puerto	N? (Specify Yes	s or No—	U.S 14. RACE Black, Specify:	- American Indian, White, etc.
ETED	15. OECEDENT'S EDUCAT (Specify only highest grade cor	ION npleted) College (1-4 or 5+)	18a. DECEDENT'S U (Give kind of wo life. Do NOT use HOME Mal-	rk done during ma retired.)			Own Ho		JSTRY	White
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Peter 19a. WFORMANT'S NAME (Type/Print)	Sc	carpulla		ta. MOTHER'S N. Lucia nd Number or Rural	AME (First,	Middle, Malden	Surname)	Ciano	i
2	Mrs. Nellie R. Do. 20a. METHOD OF DISPOSITION 1 Suriat 2 Cremation 3 Gemova 4 Donatton 5 Other (Specify)	from State		49th S	St.APT.	5C Ne	E 20c. LO	k, Nev	V YOY	i, Stata
	21. SIGNATURE OF FUNCTIAL SERVICE LICEN	SEE SEE		Ruck	Towson	Fune:	cal Ho	me Inc	2.	u.
CATION	23. PART I. Enter the diseases, or conshock, or heart failure. Lis iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS	aach lina.					iratory arre	st,	Approximate interval Between Onset and Death 2 days 4 days
MEDICAL CERTIFICATION	that initiated events resulting in death) LAST PART II. Other aignificant conditions of		A CONSEQUENCE OF)		; cause given in	Part I.	24a. WAS AN PERFOF 1 YES 2	RMED?	C	ERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2. NO
PHYSICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	OSPITAL:	26. PLACE OF DEATH	(Check only one)						
B	27. MANNER OF DEATH 1 N Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY	28b. TIME INJU	OF 28c. INJ NY WO	RK? ES 2 NO	28d, DE:	SCRIBE HOW I			to Mumber
COMPLETED	4 Homicide determined 29a. CERTIFIER (Check only)	building, atc. (Spe	icify)			City	or Town, State)			
TO BE COM	296. SIGNATURE AND TITLE OF CERTIFIER M SUCCESSION STORE 296. SIGNATURE AND TITLE OF CERTIFIER	vorts /10/			29c. LICENSE NU	MBER		29d, DATE	SIGNED (A	Ionth, Day, Year)
-	30. NAME AND ADDRESS OF PERSON WHO CO STE	OMPLETED CAUSE OF DE	11339	LITTLE	PATUX	ENT	PKWY	431	000	21044 WM BA MD

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 50 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

500								
ITEM:	4.	PER	F.H.	FILM	G-718	12/	19/5	34 t.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEAL ATE OF DE		MENTAL	HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	RAMSEUR				HTHOM	OF DEATH DA	Y YE		OF DEATH
	4. SOCIAL SECURITY 243-86-472		(In yrs. last birthday) IF		INDER 24 HRS.	7. DATE 0		8. B	IRTNPLACE (S	itate or Foreign
	21486 1121	1 D M 2 X F	70 YRS.	NTHS DAYS HOU		June	1511	954 N	orth (avolina
OR	TOETY Medi	cal Cont	en	CITY, TOWN OR LO	limo			9c. COUNTY	OF DEATH	
DIRECTOR	10e. STATE 10b. COUNTY	r	10c. CITY, TO	OWN OR LOCATION		1				IDE CITY
	100. STREET AND NUMBER			allimon 101, ZIP		Y			1 X YE	S 2 NO
FUNERAL	2004 N. forest	- Park av	enu-e	2	120'	7		10g. CITIZEN	SH	JN I RT7
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS DECENDE If yes, specify (Guben, Mexica	n, Puerto R	(Specify Yes Ican, etc.)	or No- 14. F	RACE - Amer Black, White, o	ican Indien, itc.
D BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 🗌 YES 2	(NO Specifi			1	3 lac	<u>C</u>
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	(Give kind of work	done during most of w	working	16b.	KINO OF BUS	INESS/INOUSTI	RY	
MPL	12	6	Homen	1a Cer		(Jun	Hon	e	
BE CC	17. FITHER'S NAME (First, Middle, Last)	1911S		16, 1	Vern	ME (First, M	iddle, Meiden :	Surname)		
TO B	190. INFORMANT'S NAME (Type/Print)	2111-18	19b. MAILING AD	DRESS (Street and Nu	imper or Regal I	Route Numbe	er, City or Town	State, Zip Code) 111	D. A. a. a.
	20a METHOD OF DISPOSITION	eur, 377	PLACE AND DATE OF D	ISPOSITION (Name of	1 10	VL C	20c. LOC	CATION - City	or Town, State	4207
	1 Buriel 2 Cremetion 3 Rem	oval from State	petery, crematory or other	forest	7/	5/94	DWI	mgs M	ills,	nd
	21. SIGNATURE OF FUNERAL SERVICE LIC	4 B)	JOSEICE	DRESS OF FA	CILIPA US	es f	mero	of the	ma
	23. PARY I. Enter the diseases, or o	complications that caused	the death. Do not	enter the mode of	dying, auc	h ae cardi	ac or reapin	atory arreat,	0116, A	proximate
	enock, or heart failure. IMMEDIATE CAUSE (Final	Liat only one cause on e	ach lina.					= 11.	Int	erval Between set and Death
	disease or condition resulting in desth)	e. DUE TO (OR AS A	CONSEQUENCE OF):	niev						
NO	Sequentielly list conditions,	b								
CATI	if any, leeding to immediata cause. Enter UNDERLYING	C.	CONSEQUENCE OF):							
CERTIFICATION	CAUSE (Disease or Injury thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
	DART II. Other algoliterat condition	d.			participation of					
PHYSICIAN: MEDICAL	PART II. Other eignificent condition	e contributing to deeth b	ut not resulting in ti	he underlying cau	iae given in	Part I.	24a. WAS AN / PERFORI	MED?	AVAILABL	TOPSY FINDINGS LE PRIOR TO TION OF CAUSE
MED							1 TYES 2	- NO	OF DEAT	N7 S 2 NO
AN	DID TOBACCO USE CONTI		F DEATH YES		NCERTAIN	И П				
SICI	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp	0	THER: Nursing Home 5	Residence	8 🗆 Other	(Specify)			
	27. MANNER OF OEATN 1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	WORK?		28d. OE\$0	CRIBE HOW IN	JURY OCCURE	D	
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spec	— At home, term, atree		2 NO	281. LOCA	TION (Street as	nd Number or Ru	iral Route Num	ber,
ETE	4 Nomicide determined									
COMPLETED	(Check only GENTIFTING PNYSI	CIAN: To the best of my knowl R: On the basic of exemination							ise(s) end mer	nner es stated.
BE CC	296 SIGNATURE AND TITLE OF CERTIFIER				LICENSE NUN			29d. DATE SIG		
10 8	30, NAME AND ADDRESS OF PERSON WIN	Mowen	L MD	19	36/	46		15.	-12-	94
	KATHERINE	O COMPLETEO CAUSE OF DE	AITI (ITEM 27) (Type, Prin	,22504	TH GK	SPEN.	IR ST	BA	MM	ORH
	31. DATE FILED (Month, Day, Year) DEC1 3 1994	32. REGISTRAR'S SIGN.		1			,			

 ermit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

D BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	ter death. Page 6 may be retained by the hospital or attending physician,
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28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remove	wal,
	28 is marked, or item 23 shows any injury, or other traumatic event, the medical	si examiner must be notified at once.

505									J 4	J	0110
1 - STATE REGISTRAR		STATE OF M	MARYLAN			F HEALTH AND OF DEATH	MENT	AL HYGIEN REG. NO.	_		
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
BENJAMIN		Н.		RUSS		SR.	DE	<u>"</u>	9 19	9 ⁴ 4 ⁿ	6:43 A _M
4. SOCIAL SECURITY NUME 578-26-2521		5. SEX 1 X M 2 □ F	6. AGE (In yr	rs. last birthday) YRS.	IF UNDER 1 YE	EAR IF UNDER 24 HRS.	(Mor	E OF BIRTH nth, Day, Year) 1.3,192	6	Count	HPLACE (State or Foreign try) T.OF COLUMBI
9a. FACILITY NAME (If not in						WN OR LOCATION OF	DEATH		_	NTY OF E	
RESIDENCE OF DEC		SIREEI			BA	LTIMORE	CIT	Y			
10a. STATE MARYLAND	10b. COUNTY	, IE ARUNDE	L	100	Y, TOWN OR L						10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER					7112 2 111	10f. ZIP CODE			10g, CIT	IZEN OF	1 A YES 2 NO
1135 NANTIC	OKE ST	CREET				21230	C		υ.:	S.A.	
11. MARITAL STATUS 1 Never Married 2	Marriad	12. WAS DECEDEN FORCES? 1	TEVER IN U.S	S. ARMED	t3. WAS	DECENDENT OF HISPA	ANIC ORIG	IN? (Specify Yes	or No-		E — American Indian, k, White, etc.
3 K Widowed 4 □ Divo	rced	IF YES, GIVE W	WW I	S		YES 2 XNO Spec				Spec	
(Specify only	EDENT'S EDUC highest grade	CATION completed)	164	(Give kind of a life, Do NOT us	vork done durin	PATION g most of working	16	b. KIND OF BUS	SINESS/INI	DUSTRY	
Elementary/Secondary (0 10TH GRADE		College [1-4 or 5 +		.V. REI		N	S	SELF-EM	PLOY	ED	
17. FATHER'S NAME (First, M. GEORGE H. R								Middle, Maiden DELL			
19a. INFORMANT'S NAME (7)						reet and Number or Rura					
MRS. EDNA E						STREET -				212	
1 N Burial 2 Crematio	n 3 🗆 Ramo	oval from State	cemeter	ACE AND DATE OF STREET OF	ther piece)		12/		CATION — LTIM		own, State
21. SIGNATURE OF FUNERAL	L SERVICE LIG	ENSER	11		22. NAN	E ANO ADDRESS OF F	ACILITY			OTCL	
Tem	2 (Smil				ARD FUNERA WILKENS A				ORE.	MD 21229
23. PART I. Enter the di shock, or he	seases, or c	omplications that list only one cau	ceused the	a daath. Do n	ot antar tha	moda of dying, au	ich es cai	rdiac or reapi	retory an	rest,	Approximate Interval Between
iMMEDIATE CAUSE (Fin disease or condition resulting in deeth)	eal →	I freun	COR AS A CO	NSEQUENCE OF	licati	-g Artem	scleps	tic Con	Lyn	ila (Onset and Death
Sequantially list conditi			(011 113 11 00	MOLGOENCE OF):						
If any, leading to immed cause. Enter UNDERLY	diata	OUE TO	OR AS A CO	NSEQUENCE OF	7):						
CAUSE (Disease or Inju		OUE TO	OR AS A CO	NSEQUENCE OF	7:						
reaulting in death) LAS	T L a	ı .									
PART II. Other significa	nt condition	s contributing to	death but n	not resulting i	n the undar	lying causa givan lı	n Part I.	24a, WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS
				_				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
			_					100			DE OEATH?
DID TOBACCO U		IBUTE TO CA			S NO		IN 🗆				/\
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DEAT	OTHER:						***
1 X YES 2 NO		1 Inpatient 2 I		26b, TIM		Home 5 Residence	_	er (Specify) ESCRIBE HOW II	LILIBY OC	CHRED	
	Pending investigation	(Month, Di	ly, Year)	INJ	M 1	WORK?	200.00	SONIBL NOW IF		CONED	
						date and place, and du					
		: On the basis of ex	amination and	d/or investigation	n, in my opinio	on, death occured at th	e time, dat	te and placa, and	due to th	na cause(a	a) and manner as stated.
286. SIGNATURE AND TITLE	OF CERTIFIER	11	,	0		29c. LICENSE NO			29d. DAT	E SIGNED	(Month, Day, Year)
38 NAME AND ADDRESS OF	IN NAME AND ADDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH (ITEM 27) (Type, Print)										
THEODORE	111 Penn Street, Baltimore, Maryland 21201										
DEC. 13	1994	ALLA DILUE	Locks	RE							
-0	1001	71									DHMH-16 Rev 1/89

use as the burial-transit funeral director, page 5 should be detached for retained by t pe Раде 6 тау filled in by the fu 6 cremation, an and completely f the death certificate be the attending physician Mental Hygiene prior to signed by the t, of h has b

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Pages 1, 2, 3

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Item certificate I

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30. NAME AND ADDRESS OF PERSON WHO COM

A-Tarib

Khalid

31. DATE FILEO (Month, Day, 16ar)
DEC1_3 1994

this c marked,

DIRECTOR; After the hours after death v

HOSPITAL FUNERAL I =

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

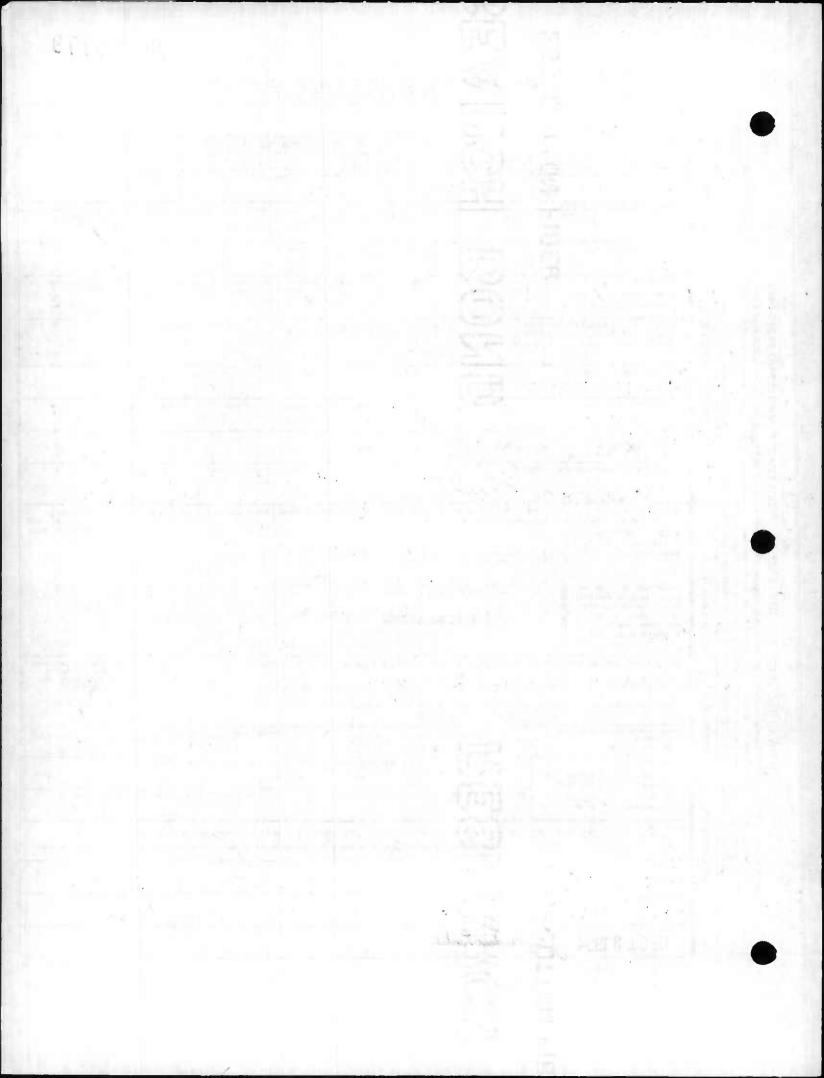
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF OFATH usse robert 6.35 a. m 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. A. BIRTHPLACE (State or Foreign (Month, Day, Year) 4-22-1934 1 M 2 D F 215-30-9471 DAYS HOURS 60 YRS. MARYLAND 9a. FACILITY NAME (If not institution, give str Sh. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CHURCH HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10h, COUNT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 201 NORTH BROADWAY 21231 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11 MADITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 84 Specify: 3 Widowed 4 Divorced WHITE ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
ille. Do NOT use retired.) 15. DECEDENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY (Specify only high Etementary/Secondary (0-12) College (1-4 or 5+) COMPL SALES REPRESENTATIVE CAR SALES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) EDWIN ALLEN RUSSELL CHARLOTTE HEUISLER BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARY C. WATTS 1810 RUXTON RD. TOWSON, MD. 21204. 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION /Name of OATE GREEN MOUNT CREMATORY 12/94 BALTO., MD. 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart fellure. List only one ceuse on each line Onsat and Desth IMMEDIATE CAUSE (Final disease or condition resulting in deeth) HEROCITIC Encephalogathy DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, If any, leeding to immediate OCH AS A CONSEQUENCE OF): cause, Enter UNDERLYING Circhos CAUSE (Disesse or Injury thet initieted events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Chack only)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. MICHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

LETED CAUSE OF OEATH (ITEM 27) (Type, Print,

3 RECHETRAR'S GRATUR

Church Home Hapital



B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM G-719 1/23/95 t.t Item22 12-13-94 FilmG718 W.H.Per F/H

94 36780

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 -	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HE CERTIFICATE OF I	
1, (DECEDENT'S NAME (First, Middle, Last)	CERTO III	2. DATE OF DEATH

	ricals mark	OLITTIII	AIL OI DEAT	HEG. NO).					
	1. DECEDENT'S NAME (First, Middle, Last) CHARLES J. SERIO IV 2. DATE OF DEATH MONTH DAY DEC. 11 94 0910									
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In y		UNDER 1 YEAR IF UNDER 2	4 HRS. 7. DATE OF BIRTH	1 94 0910 A M 8. BIRTHPLACE (State or Foreign Country)					
	1 € M 2 □ F	YRS.	3 18 HOURS	August 23,	1994 Maryland					
8	99. FACILITY NAME (If not institution, give street and number) 647 SOUTH PULASKI STREET		BALTIMORE		9c. COUNTY OF DEATH					
<u>ان</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Line City 1	OWN OR LOCATION							
DIRECTOR	Md.		ltimore		10d, INSIDE CITY LIMITS? 1 X YES 2 NO					
FUNERAL	100, STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
W	1804 Wilhelm St.		2122		USA					
₽	11. WAS DECEDENT EVER IN U. 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U. FORCES? 1 YES : IF YES, GIVE WAR OR DATE	2 XNO	13. WAS DECENDENT OF If yea, specify Cuban, 1 YES 2 NO	14. RACE — American Indian, Black, Whita, etc. Specity: White						
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	Sa. DECEDENT'S US	done during most of working	16b, KIND OF BU	JSINESS/INDUSTRY					
Ä	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use r	etired.)							
ONCE.	17. FATHER'S NAME (First, Middle, Last)	Infa		FRIO MANE (First Addition of the						
	Charles J. Serio. III			ER'S NAME (First, Middle, Maider						
fled a	19a, INFORMANT'S NAME (Type/Print)	19b. MAILING AL		ISSY L. Weath						
10	Crissy L. Weatherly	1804 W	ilhelm St	Baltimore, M	d 21223					
must be notified at once. TO BE COM	20a. METHOD OF DISPOSITION 20b. PL	ACE AND DATE OF	DISPOSITION (Name of	DATE 20c. 1.0	DCATION — City or Town, State					
Ē	Loudon Park Cemetery 12/15 Baltimore, Md.									
examiner	22. NAME AND ADDRÉSS OF SAME ITY Gary L. Kaufman Funeral Home of Elk., Inc.									
- B	23. PART I. Enter the diseases, or complications that coxised the death. Do not enter the mode of dying, such as cordisc or respiratory arrest, Approximate									
nt, the medical	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SUDDEN INFANT DEATH SYNDROME									
any injury, or other traumatic event,	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING									
FIC	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):									
BHT.	resulting in death) LAST									
S S	PART II. Other significant conditions contributing to death but	not resulting in	he underlying cause of	van in Part I 240 une 40	ALITOROV 245 WERE ALITOROV ENIONION					
EDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE									
\$ <u>U</u>	OF DEATH?									
2 2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF I	DEATH YES	□ NO □ UNCE	RTAIN 🗆	YES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26.	PLACE OF DEATH	Check only one)							
VSICI/	EXAMINEN? Y(X) YES 2 □ NO		THER: □ Nursing Home 5 🎇 Rasi	Idenca 6 Other (Specify)						
E 18	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME C		28d. DESCRIBE HOW	INJURY OCCURED					
marked, BY PH	1 \(\)\(\)\(\)\(\)\(\)\(\)\(\)\(M 1 YES 2	NO						
ED 28	3 Suicide 8 Could not be 4 Homicide detarmined 28e. PLACE OF INJURY — building, afc. (Specify)	At homa, farm, etre	et, fectory, office	281. LOCATION (Street City or Town, State	and Number or Rural Route Number,)					
D BE COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge one) 2XXMEDICAL EXAMINER: On the best of my knowledge one)									
S S	29b. SIGNATURE AND THEE OF SERTISIED			ISE NUMBER						
BE BE	gral			C.M.E	29d. DATE SIGNED (Month, Day, Year) ▶ DEC. 12, 1994					
₽	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	I (ITEM 27) (Type, Pri	nt)							
			Street, E	Baltimore,	Maryland 21201					
	31. DATE FILED (Morith, Day, Year) 32. BEGISTRAR'S SIGNATU									

Agreement of the State of Stat

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ITEMS: 23 PART I, 27, 28a-f, PEP MEO FILM G-718 12/13/94 t.t

Film# G-718 12/13/94 R.M. F.H.

Item#4 Per FOR 1 - STATE BEGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN		CERTIFI	CATE OF	DEATH	REG	i. NO		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEA	TH DAY	3. TIME OF OEATH	
	RONALD SWAN	SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	<u> </u>	94 6:17 E	
	11/1/2 /1/2 24	1 X M 2 🗆 F		MONTHS DAYS	HOURS MIN.	(Month, Day, Y	0 1043	Country)	
	9a. FACILITY NAME (If not institution, give stre	net and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNT	Y OF DEATH	
OR		OURT		BALTI	MORE CI	TY			
ECT	RESIDENCE OF DECEDENT 10a. STATE 1 10b. COUNTY		I 10c. CITY	TOWN OR LOCA	TION			10d. INSIDE CITY	
DIRECTOR	Mary had		F	Baltin				LIMITS?	
AL	10e. STREET AND NUMBER	- 1			1. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?	
FUNERAL	1613 Kuxlon	AUENU	e=		2121	6		USA	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES	2 NO	If yea, ap	CENDENT OF HISPA			I. RACE — American Indian, Black, White, atc.	
ΒY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 🗆 YES	3 2 NO Speci	fy:		Black	
ETED	15. DECEDENT'S EOUCA (Specify only highest grade of		16a. DECEDENT'S U	ISUAL OCCUPATE ork done during mo		16b. KIND C	F BUSINESS/INDU	STRY	
	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	retired.)	or or working		AIrpor	+	
COMPL	17. FATHER'S NAME (Flow, Middle/ Last)	0	0031	va IqII	40 4007115717			,	
	Paul Phillips				18. NOTHER'S N	AMERICANISMICATION N	Ton O I		
) BE	19a. INFORMANT'S NAME (Type/Ppin)	P	19b, MAJLING	ADDRESS (Street	and Number or Rural	Boute Number, City	or Town, Style, Zip C	ode)	
٩		2017	1613	Pruxto	n. Bal	to, Md	212	16	
	20a, METHOD OF DISPOSITION 1) Burlel 2 Cremation 3 Remov		b. PLACE AND DATE OF		ame of	SPATE 2	C. LOCATION — CI	y or Town, Slata	
1	4 Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		amson -	TOPESI	Cem	70/9/L	Juings /	VIIIs, NO	
	De 40 MA	Pluse)	JOSE	ND ADDRESS OF F	RUSS 7	Lineral	Home	
_	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate								
	IMMEDIATE CAUSE (Final disease or condition recuiting in death)	ACUTE ETHANO	L AND NARCO		(ICATION			Onset and E	
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate OUE TO (OR AS A CONSEQUENCE OF):								
	CAUSE (Disease or Injury CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF):								
	thet initiated events resulting in death) LAST								
	DART II Other elevidicent conditions								
EDICAL	PART II. Other eignificant conditions	contributing to deeth i	but not resulting in	the underlyin	g cause given in	PE	AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FIND AWAILABLE PRIOR TO COMPLETION DF CAU	
						— 'X'	ES 2 NO	DF DEATH?	
W ::	DID TOBACCO USE CONTRI	BUTE TO CAUSE C	OF DEATH YES	П NO Г	UNCERTAI	N []		1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEATH	(Check only one)					
YSI	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out		OTHER: 4 Nursing Hore	ne 5 🗆 Residenca	8 XOther (Specify	AT SC	ENE	
품	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	EOUND	RXT. WO	JURY AT DRK?	28d. OEŞCRIBE I	HOW INJURY OCCU	RED	
B	2 Accident Investigation	FOUND 12-2-9	14 0:17	P	YES 2XX NO	UNKNOWN			
	3 Suicide 6 XX Could not be determined	building, atc. (Spe	cify)			City or Town,	State) #17 N	Rural Route Number. VINCENT STREET	
LET	29a, CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my know	IN VACANT		and also is 4.5	BAL I IMURE	, MARYLAND		
COMPL								euse(e) end manner ee stat	
E C	29b. SIGNATURE AND TITLE OF CERTIFIER	01			29c. LICENSE NU			IGNED (Month, Day, Year)	
∞ ∥	Dermin f.						C 3,1994		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OR			reet. F	Baltimo	re, Mar	yland 2120	
	31. DATE FILED (Month, Day, Year)	37 REGISTRAR'S SIGN						1	
	DEC1 3 1994	JOSEA DIMENSO	- Francis						

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THE HOSFITH, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex nours after death. Page 6 may be retained by the hospital or attending physician.	THE HUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be used to the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
10 7年 158	TO THE FUR be filed with	IMPORTAN	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / OEPARTM CERTIFIC	ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN				
- 6	1. DECEDENT'S NAME (First, Middle, Last)	Sho	wpe_		2. DATE OF DEATH		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 265-50-9960	5. SEX B. AGE (In		UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) QUO -20, 19	38 -	BIRTHPLACE (State or Foreign		
OR	15. South Ce	Hen Road	d 96	Perry Ha	1-10-	9c. COUNTY			
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATION OFFICE Hall			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	100. STREET AND NUMBER	-lan Pag	1	101. ZIP CODE	/	10g. CITIZEN	OF WHAT COUNTRY?		
Y FUNERAL	1 Never Married 2 Married	12. WAS OECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISP/ If yea, specify Cuben, Maxic 1 YES 2 NO Spec	en, Puerto Ricen, etc.)	or No 14,	RACE — American Indian, Black, White, atc.		
ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUCAT (Specify only highest grade co	TION	16. DECEDENT'S USU	AL OCCUPATION	16b. KIND OF BU	SINESS/INOUST	White		
COMPLETED		College (1-4 or 5+)	Mo DONOT USO POL	done during most of working ired.)	Se	Belf-employed			
	17. FATHER'S NAME (First, Middle, Last)	P.		16. MOTHER'S N	AME (First, Middle, Majden		1		
TO BE	190. INFORMANT'S NAME (Type/Printy	ne	19b. MAILING AD	DRESS (Street and Yumber of Rura	Poute Number, City or Tow	m, State, Zip Coo	2014.31		
	20sr METHOD OF DISPOSITION 1 Buriel 2 Cremellon 3 Ramovi Donation 5 Other (Specify)	al from State	PLACE AND DATE OF DI	SPOSITION / Numeral	PAJATE POL	CATION — City	or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE CO	minum y	22. NAME AND ADDREAS OF S	ACILITY OF THE	Cenon	al Home		
4	23. PARTA. Enter the diseases, or con	mplications that caused	the death. Do not a	BREEN.	north a	ve, Be	ulto, no		
	IMMEDIATE CAUSE (Finel	et only one ceuse on esc	ch line.			iretory srrest,	Approximate Interval Between Onset and Death		
	disease or condition resulting in deeth) e.	POWE TO (OR AS A C		que Can	cer	<u> </u>			
NO N	Sequentially list conditions, If any, leading to immediate b. OUE TO (OR AS A CONSEQUENCE OF):								
FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST								
A	PART II. Other significant conditions	contributing to death but	t not resulting in th	ne underlying cause given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC					1 D YES :	MNO	OF DEATH?		
CIAN	DID TOBACCO USE CONTRII 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		B. PLACE OF OEATH (C	heck only one)					
IXSI		☐ Inpetient 2 ☐ ER/Oulpet	lent 3 DOA 4	HER: Nursing Home 5 - Residence					
ВУ Р	1 Nstural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 YES 2 NO	28d. OEŞCRIBE HOW	NJURY OCCURE	ED		
ETED	2 Acctdent 3 Suicide 6 Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined 26e. PLACE OF INJURY — At home, farm, street, factory, office Could not be determined City or Town, Stete) City or Town, Stete)								
٦				the time, data and place, and du my opinion, death occured at th					
BE COM	296. SIGNATURE AND TITLE OF CERTIFIER	on the season axenimisators	araor invostigation, in	29s. LICENSE NO			INED,(Month, Day, Hear)		
TOB	30. NAME AND ACCURAGE OF PERSON WHO C	OMPLETED CAUSE OF DEAD	H (ITEM 27) /7/pis. Prin	D450	039	▶ 12	1-194		
	WILLIAM BJ	ackson ~	1D						
	DECI 3 1994 Jul	Davelson Rend	all						



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) AKA 3. TIME OF DEATH M 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday Jan. 29 DAYS HOURS Virginia 225 28 2461 1 M 2 SEF 75 YRS. 1919 the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION TOWSON 10a. STATE 10b. COUNTY 10d. INSIDE CITY Maryland Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 305 E. Joppa Rd. Apt. 1803 21286 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ADMED FORCES? 1 YES 2 7NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puarlo Rican, etc.)

1 YES 2 100 Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES Never Married 2 Married White 3 Wildowed 4 Divorced Specify. ВY COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary Secondary (0-12) College (1-4 or 5 +) Waitress -Restraunt-RESTAURANT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Surname) Joseph Jasper Ħ BE 19a. INFORMANT'S NAME (Type/Print)
Priscilla Churchman notified 196, MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, State, Zip Code)
2901 Boston St. Unit 106 Baltimore, MD 21224 9 pe 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 8 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Green Mount ole Grematory 20c. LOCATION - City or Town, State must examiner 22. NAME AND ADDRESS OF FACULTY Bruzdzinski Funeral Home PA Baltimore, MD 21221 1407 Eastern Ave. medical 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximate shock, or heart feliure. List only one cause on each line. intervei Between 5 **IMMEDIATE CAUSE (Finel** Onset and Death the cremation, disease or condition_ FAILURE OR n and completely fi to burial, cremation resulting in deeth) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): ung physician and Hygiene prim if any, leeding to immediate cause. Enter UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events the attending p resulting in deeth) LAST 0 PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? PERFORMED? HERRI any Signed Health a 1 YES 2 NO 1 TES 2 NO been s PHYSICIAN: HOSPITAL DR ATTENDING PHYSICIAN: The law is FUNERAL DIRECTOR: After this certificate has be within 72 hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpetiant 2 ER/Outpetiant 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO ВY 2 Accident 28s. PLACE OF INJURY — A1 home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 8 Could not be COMPLETED 28 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE FUNERAL ID THE FUNERAL ID BE filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ▶ DECEMBER 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 800 Samore Tran 11 CAR BOUTMORG DEC13 32. REGISTRAR'S SIGNATURE Davidson

DHMH-16 Rev 1/89

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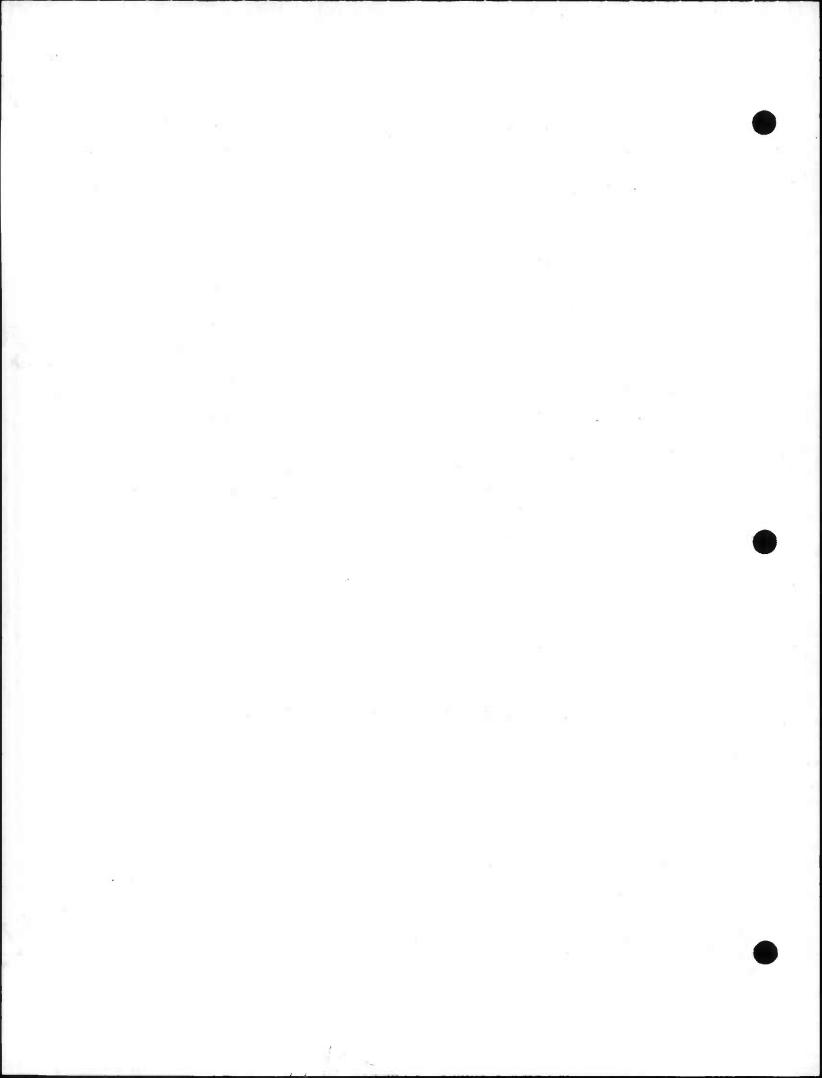
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fer death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should wal.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with norms after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

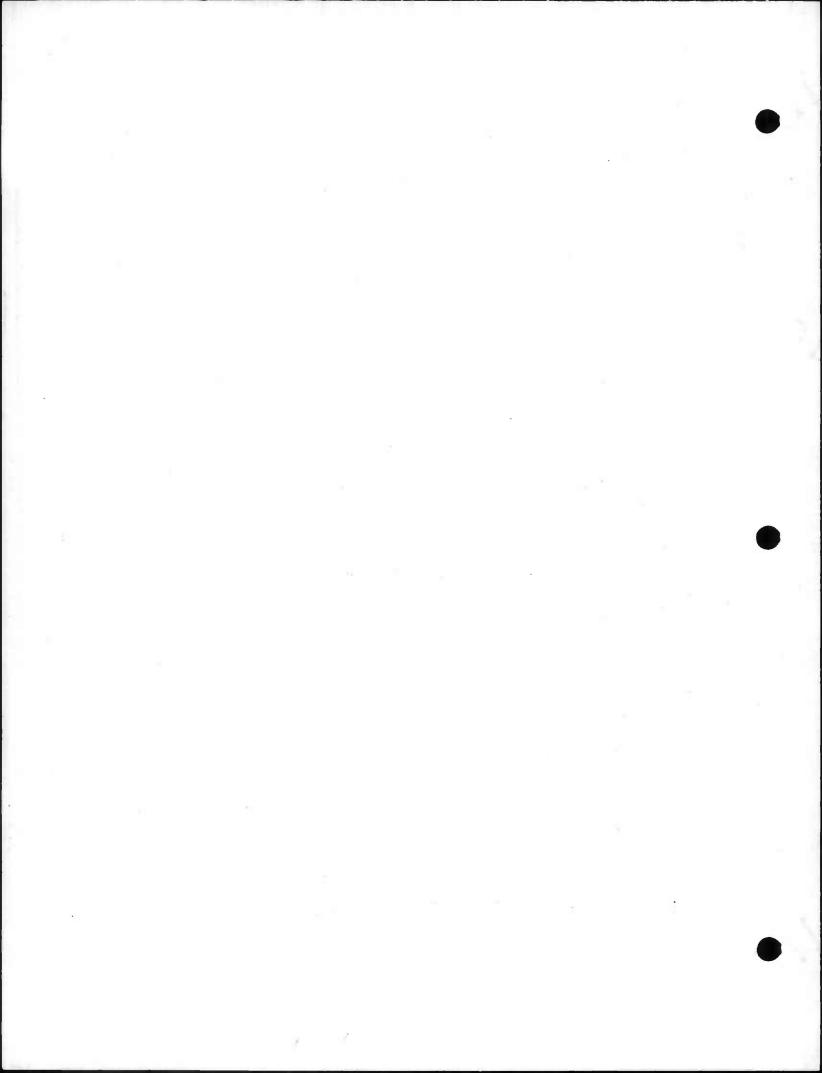
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND N	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH	3. TIME OF OEATH			
	JEFF FRANKLIN SAN	FF FRANKLIN SANDIDGE					DECEMBER 11. 1994			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	A. BIRTH	1:45 P M		
	436 12 8664 9a. FACILITY NAME (If not institution, give stre		2 YRS.	MONTHS DAYS	HOURS MIN.	JULY 7,192		ISIANA		
5	FT. HOWARD VETERAN				OWARD	ATH 9	BALTI			
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY		
DIMECTOR	MARYLAND			BALTIM			LIMITS?			
FUNERAL	1724 SPENCE STRE	ET		101	21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
5		12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC		IC ORIGIN? (Specify Yea or		- American Indian,		
	1 Never Married 2 🕅 Married	FORCES? TY YES	2 NO	If yes, sp		n, Puarto Rican, etc.)	Black	, White, atc.		
5	3 Widowed 4 Divorced	WW		1 1 163	Z M NO Specify		Specia	WHITE		
3	15. OECEDENT'S EDUCA (Specify only highest grade of	TION	16a. DECEDENT'S U	SUAL OCCUPATION done during mo		16b, KIND OF BUSINE	ESS/INOUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)	MACHIN	retired.)	st or working	HUTZLER				
COMPL	8TH GRADE		MACHI	1121						
	17. FATHER'S NAME (First, Middle, Last) TOM SANDIDGE					ME (First, Middle, Maiden Sun HATTEN	name)			
2	19a. INFORMANT'S NAME (Type/Print) JOSEPHINE D SAND	IDGE				laute Number, City or Town, S BALTIM ORE		21223		
	20a. METHOD OF DISPOSITION	al from State 20	b. PLACE AND DATE OF	DISPOSITION (Na			TON — City or To	wn, Stata		
	1 → Burial 2 □ Cremation 3 □ Ramov 4 □ Donation 5 □ Other (Specify)		ADOWRIDGE	E MEMORI			KRIDGE			
	21. SIGNATURE OF FUMERAL SERVICE LIES	HORE //			D ADDRESS OF FAC	AL HOME, IN	C			
	1 falls/V	Joesh				AVENUE-BALT		MD 21229		
HILLAHON	shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) LARYNGEAL CANCER DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
5	PART II. Other significent conditions contributing to deeth but not resulting in the undarlying cause given in Part it. 24a. WAS AN AUTOPSY FINDINGS									
EDICAL	PANT II. Other significent conditione	cause given in	Part I. 24s. WAS AN AUT PERFORME 1 YES 2 X	D?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?					
Σ	DID TORACCO HEE C	ONTRIBUTE TO	CALICE OF	DEATH N	re tri No			1 TYES 2 NO		
SICIAIN	DID TOBACCO USE CO	ONIKIBUTE TO	CAUSE OF		ES X NO					
2		HOSPITAL:	COLOR V P P P	OTHER:	ACE OF DEATH (Che					
2	27. MANNER OF DEATH	26s. OATE OF INJURY	patient 3 L DOA 28b, TIME		e 5 🗆 Rasidenca					
	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	RY WO	RK?	28d. OEŞCRIBE HOW INJU	JRY OCCURED			
	3 Suicide 8 Could not be 4 Homicide detarmined		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
	29s. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
5	one) 2 MEDICAL EXAMINER:	On the beals of examination	on and/or investigation	, in my opinion, d	eath occured at the	time, data and place, and d	us to the cause(s	and menner as stated.		
	SIGNATURE AND TITLE OF CENTERER	en			29c. LICENSE NUM D 4	15-788 I	Pd. DATE SIGNED	11/94 11/94		
	30. NAME AND ADDRESS OF PERSON WHO RAUL RIVERA, M.D.						21052	1		
	31. OATE FILEO (Morith, Day, Year) 12/11/1884/1 2 1004	Julia Dandes	A SPECIMENT	KOAD, E	NT HOWAL	w, FIARTLANL	21002			
	1-/1/DECT 3 1994	Gana aranga	A PURPORT							



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P.O.
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DIVISION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART				YGIENE EG. NO.			
100	1. DECEDENT'S NAME (First, Middle, Last)	SKIPPEZ				2. DATE OF DE MONTH	EATH DAY	1992	3. TIME OF DEATH 9:00 P M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR			IF UNDER 24 HRS.	7. DATE OF BI	RTH	8. BIRTHPI	LACE (State or Foreign	
7	213-30-4322 9s. FACILITY NAME (If not institution, give s	1 M 2 F 86	YRS.	ONTHS DAYS	R LOCATION OF DE	NOV.12,	1908	BALT	IMORE, MD	
IOR	HOWARD COUNTY GEN			COLUMB			36. 00	HOW		
DIRECTOR	10s. STATE 10b. COUNT		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY		
	MARYLAND AN	NE ARUNXEL	GLEN	BURNIE	ZIP CODE		La a	1 - YES 2X NO		
FUNERAL	409 FERNDALE AVEN	UE		101	21061		10g. Cr	10g. CITIZEN OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, spe	ENDENT OF HISPAR ecify Cuben, Mexica 2 NO Specifi	in, Puerto Rican,		14. RACE -	- American Indian, White, stc.	
EIED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	ICATION o completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of wor life, Do NOT use	rk done during mo:	N st of working	16b. KIND	OF BUSINESS/IN	IDUSTRY	WILLE	
COMPL	4TH GRADE		TENANT 1	FARMER		F	ARM			
_	17. FATHER'S NAME (First, Middle, Last) REX SKIPPER				18. MOTHER'S NA BERTHA		,			
<u>я</u>	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural			Vin Code		
2	MRS. EVELYN K. B	EWLEY			E AVENUE				1061	
	20s. METHOD OF DISPOSITION 1 to Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelery, cremetory or other place)								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE—BALTIMORE, MD								D 21229	
	23. PART Enter the diseases, or	complications that caused	d the death. Do no						Approximata	
	ahock, or haart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final								Interval Between Onsat and Daath	
	disease or condition resulting in death)				SDAYS					
20	Sequentially list conditions, If any, leading to immediate									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
	d									
DICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION, STROKE						PERFORMED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO							I ☐ YES 2 NO		
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
ה	1 TYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	5 Residence	6 Other (Spe	cify)			
- 1	27. MANNER OF DEATH 1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	RY WO	RK?	28d. DEŞCRIB	E HOW INJURY O	CCURED		
EU BY	2 Accident 3 Suicide 8 Could not be 4 Homicide determined 4 Homicide 5 Could not be 28s. PLACE DF INJURY — At home, term, street, factory, office building, stc. (Specify) 28s. PLACE DF INJURY — At home, term, street, factory, office City or Town, State)							ute Number,		
Mrteleu		ICIAN: To the heat of my know	lades doub assumed	at the stars date				-		
N N		ICIAN: To the best of my know ER: On the bests of exemination							and manner as stated.	
20 30	296. SISSETURE AND TITLE OF CERTIFIE				29c. LICENSE NUI		29d. DA	TE SIGNED (Month, Day, Year)	
2	10. AND ADDRESS OF PERSON WH	10 COMPLETED CAUSE OF DE	ATH (ITEM 27) (Time P	rint)	0382	76		INEC	10,1994	
-	JUSEPH GIBBONS,	NO 9501 C	HUMA DIC		, ELLI	COTT CI	TY, MD	210	042	
Ħ	DEC1 3 1994	Tilla Dandsor Re	dall							



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THE DRIVING PHYSICIAN: The law requires that the death certificate be executed within a four safer death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be must the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. rm 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	ICATE OI	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEJ							DEATN	TN 3. TIME OF DEATN			
	FRANCISCA P. SCHOE			MAKER						994	10:00 A M	
OR	4. SOCIAL SECURITY NUMBER	5. SEX 8	. AGE (In yrs. last	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTN	<i>_</i>	8. BIRTH	PLACE (State or Foreign	
	217-21-0438	1 □ M 2 🂢 F	82	YRS.	MONTHS DAYS	HOURS MIN.	APR		12	PARA	GUAY	
	10559 TWIN RIVERS								OWARD			
EG	RESIDENCE OF DECEDENT 104. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								10d. INSIDE CITY			
DIRECTOR		WARD			LUMBIA						LIMITS? 1 YES 2 X NO	
FUNERAL	100. STREET AND NUMBER 10559 TWIN RIVER	RS ROAD			1		109. CITIZEN OF WHAT COUNTRY? PARAGUAY					
FUN	11. MARITAL STATUS 1 Never Merried 2 Merried FORCES? 1 VES 2 No. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES			MED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee of If yee, specify Cuben, Mexican, Puerto Ricen, atc.) 1 ☑ YES 2 ☐ NO Specify:					or No-	Black	— American Indien, , White, etc.	
В	3 Widowed 4 Divorced				1 K YES 2 NO Specify: SPAIN Specify: WHITE							
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPOSITE			USUAL OCCUPAT			ND OF BUS	INESS/IN			
山	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	vork done during n e retired.)	lost of working	1					
필	12	NONE	F	OMEN	IAKER		0	WN HO	OME			
ő	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA	ME (First, Mide	lle, Maiden	Surneme)			
BE	GENARO PRIET	10				MARGA		ABRAI				
٩	CARLOS P. SCHOEM	AKER (SON				and Number or Rural W COURT,					21774	
	20e. METNOD OF DISPOSITION 1	noval from State	cametary, cres	matory or of	of disposition (12/13/9	DATE	2.00		City or To		
	21. SIGNATURE OF FUNEBAE SERVICE LI	CENSEE	1 METEC) Cra	MATORY 22. NAME	ND ADDRESS OF FA		<u>U</u>	4.1.OIV	PATIT	E, MD	
	* Lewesch	and of	E		LEROY	M & RUS	SELL C					
	23. PART I. Enter the diseeses, Dr	complications that	aused the de	eth. Do n	ot enter the m	TWIN KNO	h ss cardled	or respir	etory er	LA, IV	Approximate	
	shock, or heart failura. iMMEDIATE CAUSE (Finel disease or condition	List only one cause	on each line.	0		, 4			, ,		interval Between Onset and Death	
	resulting in death)	a. DUE TO (C	R AS A CONSEC	SUENCE OF	any 1	mes)				Samphin.	
NO	Sequentisity list conditions, but to ton as a consequence of:											
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury											
RTIFI	that initiated events resulting in deeth) LAST	DUE TO (O	R AS A DONSED	EVENCE OF	2						0	
S		4			0							
DICAL	PART II. Other significant condition None K		esth but not re	esuiting i	n the underlyi	ng ceuse given in	Part i. 24	PERFORI		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
VEDI	- TYWYY A	Monda					— ¹	YES 2	S NO	0	OF DEATH?	
PHYSICIAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES WOLD UNCERTAIN											
CI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			N (Check only one OTHER:)						
ΙΥS	1 UYES 2 NO	1 Inpatient 2 E				ne 5 Residence	6 🗆 Other (S					
ВУ РН	27. MANNER OF DEATN Netural 5 Pending Investigation	28e. DATE OF IN (Month, Day,		28b. TIM	E OF 26c. IP URY W	28d. DESCRIBE NOW INJURY OCCURED						
	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, building, stc. (Specify)							oute Number,				
ETED	4 Nomicide determined											
COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, dasth occurred at the time, data and place, end due to the cause(a) and manner ea stated.											
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	P Mod		29c. LICENSE NU						E SIGNED	(Month, Day, Year)	
0	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED ONLY	OF DEATH ST	4.070.07	0.1-41	D345	<i>D</i> 6		► D	eci	7/994	
	Jay I Van		NMV			orsey Hall	Or E	ШСо	H C	Ty 1	nd 21042	
	DEC1 3 1994	32. REGISTRAR	s sonature hardall							1		

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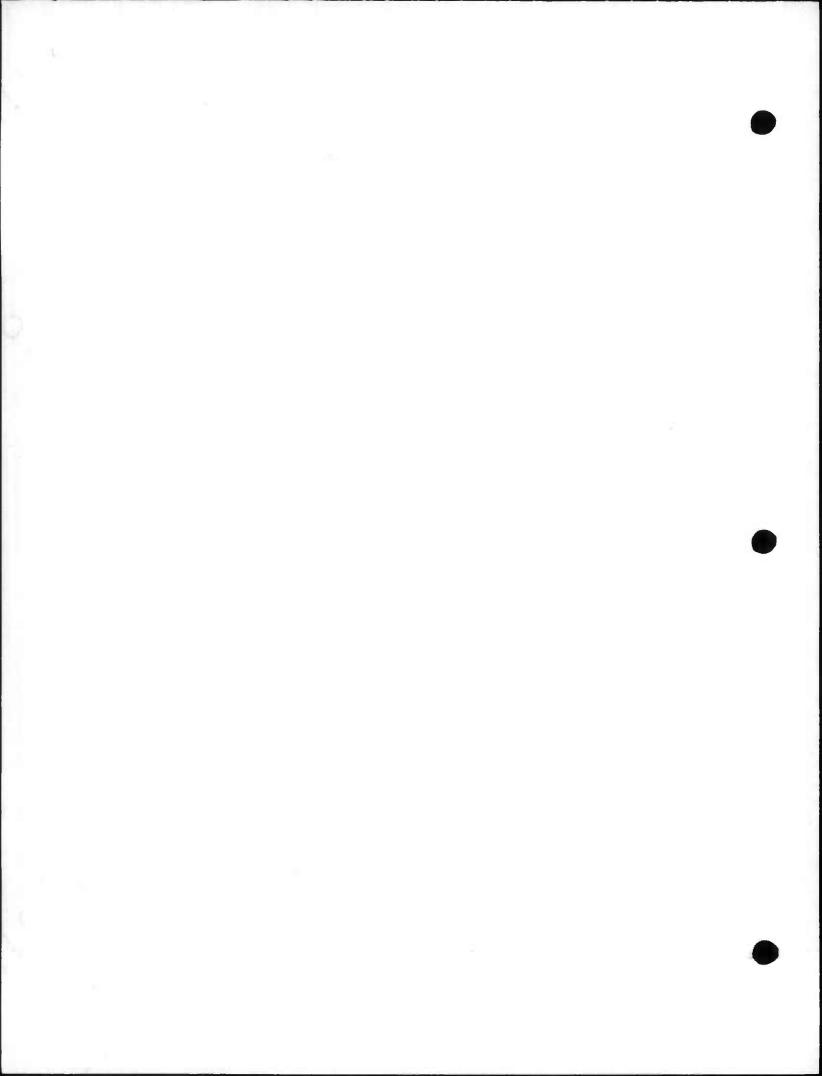
DIVISION OF VITAL RECORDS, P.O. BC

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with mounts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once. 15-0020

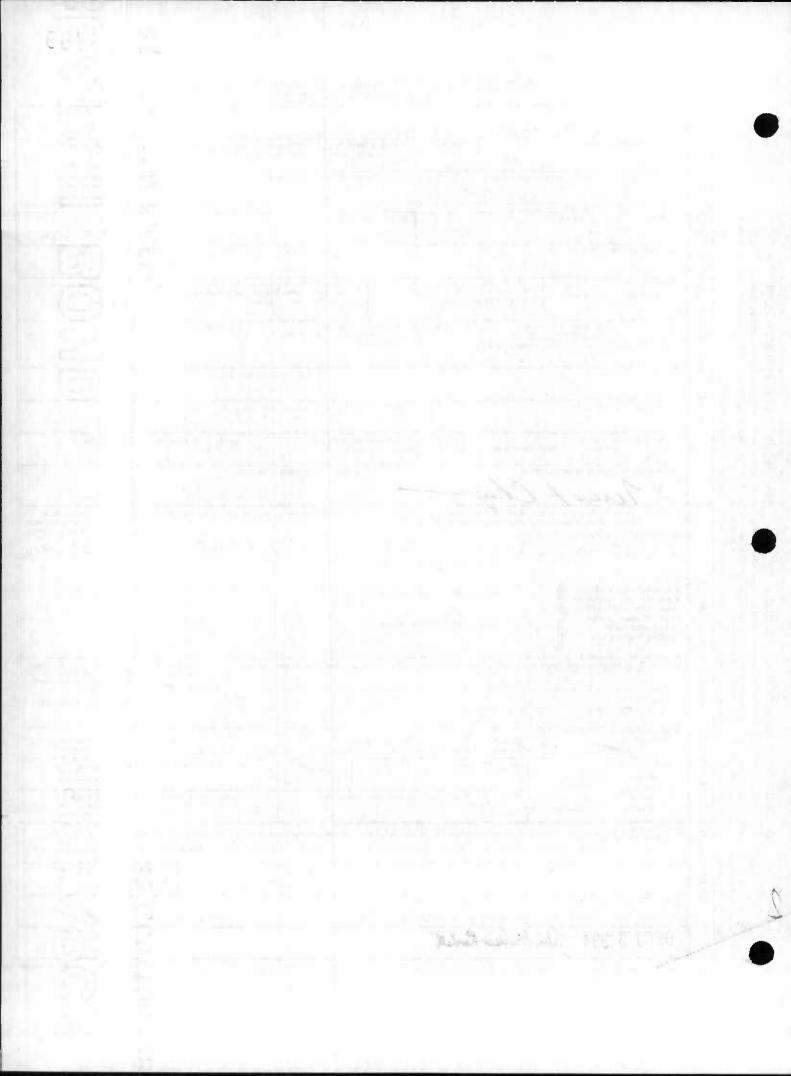
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTAL	HYGIEN	E				
1	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		_	3. TIME OF I	DEATH	
	Roxie Fife Smi	th				Dec.		994	YEAR	10:07	А. м	
15				MDER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	F BIRTH		. BIRTH	PLACE (State		
	219 56 4180 19a. FACILITY NAME (If not institution, give stree	m 2 🗓 F 101	May 18, 1893 Ohi									
DIRECTOR	Asbury Methodist Home Gaithersburg Montgomer											
l m									10d. INSIDE			
1 2	Md. Montgomery Gaithersburg								LIMITS?			
AL AL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHA									HAT COUNTR	177	
FUNERAL	Asbury Methodist H	ome			208			U.S	. A.			
l S		2. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2			NDENT OF HISPAN			a or No— 14. RACE — American Indian, Black, White, etc.				
BY F	1 Never Married 2 Married 3X Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	3 E JANO		cify Cuban, Maxica 2 X NO Specify		ican, etc.)		Specifi			
		1				_				ite		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	mpleted)	(Give kind of work of the Do NOT use reti	done during mos	N it of working	16b.	KIND OF BUS	INESS/INDU	STRY			
12	The second of th	College (1-4 or 5+)	Nurse	,			Army				11.	
N	17. FATHER'S NAME (First, Middle, Last)		S		18. MOTHER'S NA	ME (Giral M						
	John T. Fife				Candace		glin	Somanney				
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street ar	nd Number or Rural I		-	Stata Zin C	ade)			
2	Lucy Leonard				ve. C018					1794		
	20a. METHOD OF DISPOSITION	20b. PL/	ACE AND DATE OF DIS	SPOSITION /Nor	me of	DATE	20c I O	CATION - CI	N or To	un State		
	1 Burial 2 Cremation 3 Ramovi	il from State cemeters	roll cre	emation	Servic	e Dec	10.	1994	Нат	nnstea	d Md	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /		22. NAME AN	D ADDRESS OF FA	CILITY			r Hampsecau, Hu.			
	Haight Funeral Home P.O.Box 195 Sykesville, 1Md. 217							70%				
	23. PART i. Enter the diseeses, or cor	nplicetions that caused the	e death. Do not e	nter the mod	de of dying, suc	h sa cerdi	sc or respi	ratory arres	<u> </u>		ximate	
	ehock, or heert failure. Lie IMMEDIATE CAUSE (Finel	At only one ceuse on each	line.								and Death	
	disesse or condition resulting in deeth) . aspiration prelumbria days									aus		
	DUE/DO (OR AS A CONSEQUENCE OF):											
Z	Sanuardially list conditions											
OE I	Sequentially list conditions, if any, leeding to immediate											
2	CAUSE (Disease or Injury		and the second second							-		
E	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	MISEQUENCE OF):							i		
CERTIFICATION	C 4.									1		
AL.	PART ii. Other significant conditions	contributing to death but r	not resulting in th	e underlying	ceuse given in	Part I.	24a. WAS AN		24b.	WERE AUTOP		
SC						_	PERFOR			AWAILABLE PE COMPLETION OF DEATH?		
MEDIC							/			1 TYES 2	□NO	
ž	DID TOBACCO USE CO	ONTRIBUTE TO C	AUSE OF D	EATH Y	ES NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF DEATH (Ch	eck only one)					
Si		OSPITAL: Inpatient 2 ER/Outpatien	nt 3 DOA 4	Nursing Home	5 🗆 Rasidenca	8 🗆 Other	(Specify)					
표	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	JRY AT RK?	28d. DE\$6	CRIBE HOW II	NJURY OCCU	RED	-		
BY	1 Natural 5 Panding 2 Accident Investigation				ES 2 NO							
n n	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
"	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of any knowledge	e death constant	the time det	and place and d	to the	na(a) ====					
COMPLET	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated. One) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
	29b. SIGNATURE AND TITLE OF CERTIFIED	0	-							UVAN INCOME.		
H	Stevens	Teven	HIM	か	29c. LICENSE NUM	7/8	6	29d. DATE	17	19%	94	
임	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DEATH	(ITEM 27) (Torne Print		1) 10	10				111	4	
		The state of Sealing	com sej (1996, Plan	7					,	/		
	31. DATE FILED (Month, Day, Year)	32/ REGISTRAR'S SIGNATUR		T								
	DEC 1 3 1994	Muller Bender	furlaction									



BALTIMORE, MARYLAND 21203-3146	ours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely *Cd in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a pairs after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely. "Ed in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTME CERTIFICA			MENTAL	HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)	LAR.	R. SHURA			2. DATE OF	DATE OF DEATH DE GEAR 3. TIME OF DEATH THE OF DEATH					
1	4. SOCIAL SECURITY NUMBER 205-16-1258	5. SEX 8. AGE (I	AGE (in yrs. last birthday) F UNDER 1 YEAR WONTHS DAYS HOURS MIN. 7. DATE C (Month), ST. (Mon					1-23 PA,				
OR	96. FACILITY NAME (If not institution, give street and number) SHC Springfield Hospital Sykesville, Md. 9c. COUNTY OF DEATH CARLOLL											
DIRECTOR	nesidence of decedent 100. STATE 10b. COUNT Maryland	Balto. City		wn or Locati						INSIDE CITY LIMITS?		
FUNERAL	10e. STREET AND NUMBER 140 W Lafeyet	•	1 241	101.	ZIP CODE			10g. CITIZEN				
BY FUNE	11. MARITAL STATUS 1				NDENT OF HISPAN city Cuban, Mexica 2 Specify	n, Puerto Ric		or No- 14.		merican Indien, Ite, etc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	AL OCCUPATION done during mos red.)	CUPATION 16b. KIND OF BUSINESS/INDUSTRY									
립	8		None	None					ıe			
Š	17. FATHER'S NAME (First, Middle, Last)			I	18. MOTHER'S NA	ME (First, Mic	ddle, Meiden S	umame)				
BE	Frank Shura				Kathe	rine	Crup	a				
2	19e. INFORMANT'S NAME (Type/Print)		19b, MAILING ADDI	RESS (Street ar	d Number or Rural	Route Number	r, City or Town	, State, Zip Co	de)			
F	Springfield Ho	spital	6655 S	ykesv	ille R	d. Sy	kesv	ille	Md.	21784		
	20e. METHOD OF DISPOSITION 1 \(\times\) Burlel 2 \(\times\) Cremetion 3 \(\times\) Removal from State 4 \(\times\) Donetion 5 \(\times\) Other (Specify) \(\times\) Springfield Cemetery Sykesville Md.											
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		22. NAME AN	ADDRESS OF FA	CILITY	Jomo					
	Harry LU	Haight Funeral Home Box 195 Sykesville, Md. 21784										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, of heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of):											
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING BESPIRATURY ARREST. DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	CAUSE (Disease or injury that initieted events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF):											
A.	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO						AWA COM DF I	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPPLETION OF CAUSE DEATH? YES 2 NO				
-						- 1			1 100	, .20 2 8		
¥	25. WAS CASE REFERRED TO MEDICAL			28. PL	ACE OF DEATH (Ch	eck only one))					
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp		HER:	8 - Residence	8 🗆 Other	(Specify)					
/ PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 A Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOI	JRY AT		d. DESCRIBE HOW INJURY OCCURED					
red BY	2 Accident 3 Suicide 8 Could not be determined 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, strast, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)											
3 Suicide 8 Could not be determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and medical course of the cause (a) and medical course of the cause (b) and medical course of the cause (c)									I menner ee stated.			
TO BE C	PORTUO WO	MD CIM			29c. LICENSE NUI	MBER 15		29d. DATE S ▶ /2	16/	Day, Year)		
-	30. NAME AND ADDRESS OF PERSON W	HU COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print	()						1		
	31. DATE FILEO (Month, Day, Year) DEC 13 1994	32 REGISTRAR'S SIGN		S.								

	1. DECEDENT'S NAME (First, Middle, L.	JERNE T	ORIAN			MONT			EAR 10.7
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	199	BIRTNPLACE (State or
	217-24-8348	1 M 2 X F		MONTHS DAYS	HOURS MIN.	NOV.	20,192	9 N	Country) EW YORK
e	9e. FACILITY NAME (If not institution, g				OR LOCATION OF E	EATN		9c. COUNTY	
DIRECTOR	NORTHWEST	HOSPITAL		RAND	ALLSTOWN			BAL	TIMORE
IREC	MARYLAND 106, COM	n/a	10c. CITY	RAL T	IMORE				10d. INSIDE C
-	100. STREET AND NUMBER	11/ α			TITUK C.			10g, CITIZEN	↑ YES 2
FUNERAL		FTVIEW AVENU	IE		21213			UNITE	
FUN	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	R IN U.S. ARMED		CENDENT OF NISPA			r No- 14.	. RACE — American in Black, White, etc.
B	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	IF YES, GIVE WAR OR	DATES AA		S 2XX NO Spec				SpecifiBLACK
TED	15. DECEDENT'S (Specify only highest g	EDUCATION rade completed)	18a. DECEDENT'S (Give kind of w	rock done during m		168	. KIND OF BUSH	NESS/INDUS	TRY
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	CUSTODI.		HNICIAN	DE	CINAL	MANACI	EMENT APT
COMPLET	17. FATHER'S NAME (First, Middle, Last)		1 0031001	AN ILC			Middle, Maiden St		LEILINI AFI
BE C		T. LEWIS SR			GENE		BROOKS		
10	19a. INFORMANT'S NAME (Type/Print) DARLENE	НАҮ		ADDRESS (Street NDYWINE	end Number or Rural				ARYLAND 2
	28a. METHOD OF DISPOSITION	12	10b, PLACE AND DATE O	F DISPOSITION /N		DAT			y or Town, State
	1)(Suriel 2 Cremation 3 1 4 Donation 5 Other (Specify)	Removal from State	ARBUTUS M	EMORIAL	GARDE				S, MARYLA
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. NAME A	AND ADDRESS OF F		DIE 5.71		
				2000					
	23. PART I. Enter the disease, ahock, pr heart falls iMMEDIATE CAUSE (Final disease or condition resulting in death)	ire. List only one cause on	sed the death. Do not each line. RO VAS S A CONSEQUENCE OF	eventer the m		ch aa can	diac or respire	NOR	
TIFICATION	ahock, pr heart fails IMMEDIATE CAUSE (Final disease or condition	a. CERES DUE TO (OR AS	show VAS	cot enter the mo	ode of dying, su	ch aa can	diac or respire		t, Approxi
CERTIFICATION	shock, pr heart falls immediate cause. Enter UNDERLYING CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. DUE TO (OR AS	S A CONSEQUENCE OF	cot enter the mo	ode of dying, su	i DE	diac or respire	etory arrest	t, Approxi
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: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) PART II. Other algnificant conditions.	b. DUE TO (OR AS d. Lions contributing to death	S A CONSEQUENCE OF S A CONSEQUENCE OF The but not resulting in	ot enter the mo	ode of dying, su	DC	24e. WAS AN AN PERFORM	otory arread	24b. WERE AUTOPSY AMAILABLE PRIN COMPLETION C OF DEATH?
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PHYSICIAN: MEDICAL C	ahock, pr heart falls immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in death and	B. DUE TO (OR AS DUE	S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF The but not resulting in Surpetient 3 □ DOA TY 265. TIME	ot enter the money of the money	ng cause given in	i DC	24a, WAS AN A PERFORM 1 YES 2-	utopsy leor	24b. WERE AUTOPS: AMPLIABLE PRINCOMPLETION OF DEATH? 1 YES 2-6
D BY PHYSICIAN: MEDICAL C	ahock, pr heart failt IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Metural 5 Pending Investigati 3 Suicide 6 Could not	DUE TO (OR AS DUE TO	S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF The but not resulting in Supported 3 DOA TY 26b. TIME INJURY — At home, farm, s	ot enter the money of the money	PLACE OF DEATH (C) TIME 5 Residence USURY AT ONK? YES 2 NO	DC Part I. Part I. 28d, DE	24e. WAS AN AI PERFORM 1 YES 2-	UTOPSY SED?	24b. WERE AUTOPS: AMPLIABLE PRINCOMPLETION OF DEATH? 1 YES 2-6
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BE COMPLETED BY PHYSICIAN: MEDICAL C	ahock, pr heart failt IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condit 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 WO 27. MANNER OF DEATH 1 Metural 5 Pending 2 Accident 3 Suicide 6 Could not determine 29e. CERTIFIER (Check only one) 2 MEDICAL EXAM	DUE TO (OR AS DUE TO	S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF The but not resulting in The but not re	ot enter the money of the money	ode of dying, su A CC Ing cause given in PLACE OF DEATH (C) The 5 Residence SURRY AT ORK? YES 2 NO Ice	Part I. B Other 281, LOC City to the cae time, date	24e. WAS AN AI PERFORM 1 VES 2 (Or (Specify) SCRIBE NOW IN. CATION (Street enor Town, Stele) use(a) end mann e end place, end	UTOPSY IED? NO JURY OCCUP IN A Number or	24b. WERE AUTOPS: AMAILABLE PRINCOMPLETION OF DEATH? 1 YES 2-6
COMPLETED BY PHYSICIAN: MEDICAL C	ahock, pr heart failt IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condi 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 6 Could not 4 Homicide determine 299. CERTIFIER (Check only one) 2 MEDICAL EXAL 299. SI NATURE AND TITLE OF CERT	DUE TO (OR AS DUE TO	S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF The but not resulting in Surpetient 3 DOA TY 26b. Time Ty 26b. Ti	ot enter the money of the money	PLACE OF DEATH (Come 5 Residence LURY AT ORK? YES 2 NO ice	Part I. 6 Other 281, LOCCHY 1 DE LOCCHY	24e. WAS AN AI PERFORM 1 VES 2 (Or (Specify) SCRIBE NOW IN. CATION (Street enor Town, Stele) use(a) end mann e end place, end	UTOPSY EET NO JURY OCCUP or as stated, due to the c 2ed, DATE S / 2	24b. WERE AUTOPS: AMAILABLE PRINCOMPLETION OF DEATH? 1 YES 2-E



Item#20b Per F.H. Film# G-718 12/13/94 R.M. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 4:00 A 94 rnest 12 M 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year B. BIRTHPLACE (State or Foreign 2073990 91 DAYS HOURS 1 X M 2 | F Virginia Jun. 10, 1903 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Church Home Hospital Baltimore N/A Pages 1, 2, RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Baltimore 1X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 1431 E. Federal Street use as the burial-transit 21213 U.S.A. the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 MNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried BY 3 Wildowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) ğ 10th N/A detached Engineering Company Laborer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ours after death. Page 6 may be retained by the lin by the funeral director, page 5 should be of George N. Tyler at Nannie BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Tyler 1731 E. Lafayette Avenue/Baltimore, MD 21213 P 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, Stata must 20s. METHOD OF DISPOSITION

XXBurial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Park Cem. 12/14 Range 22. NAME AND ADDRESS OF FACILITY
March Funeral Home East Kien Memorial 12/14 Randallstown, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bemara 1101 E. North Ave./Baltimore, MD 21202 in by the 20 monon medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heert feliure. Liet only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Fine) Onset and Death cremation, the diseese or condition cardiomyopathy schemic resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) burial. CERTIFICATION and Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): prior to t certificate be CAUSE (Disesse or Injury other attending phys DUE TO (OR AS A CONSEQUENCE OF): that initiated evente reculting in deeth) LAST 6 the atter PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a, WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? and and any auminam signed the 1 | YES 2 | 100 Shows 1 TYES 2 THO been 0 has be Dept. PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) certificate h ltem! HOSPITAL:
1 Dippetient 2 ER/Outpetient 3 DOA OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 | YES 2 700 0 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 26d, DESCRIBE HOW INJURY OCCURED marked, this (with 2 Returns 5 Pending Investigation 1 YES 2 NO BY After t 2 Accident 28e. PLACE OF INJURY — At home, farm, street, lectory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Treen State) 69 DIRECTOR: # 6 Could not be 4 Homicide 28 ET hours a Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner ea stated. COMPL (Check only one) FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, 296. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE unk 12 2 NO AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

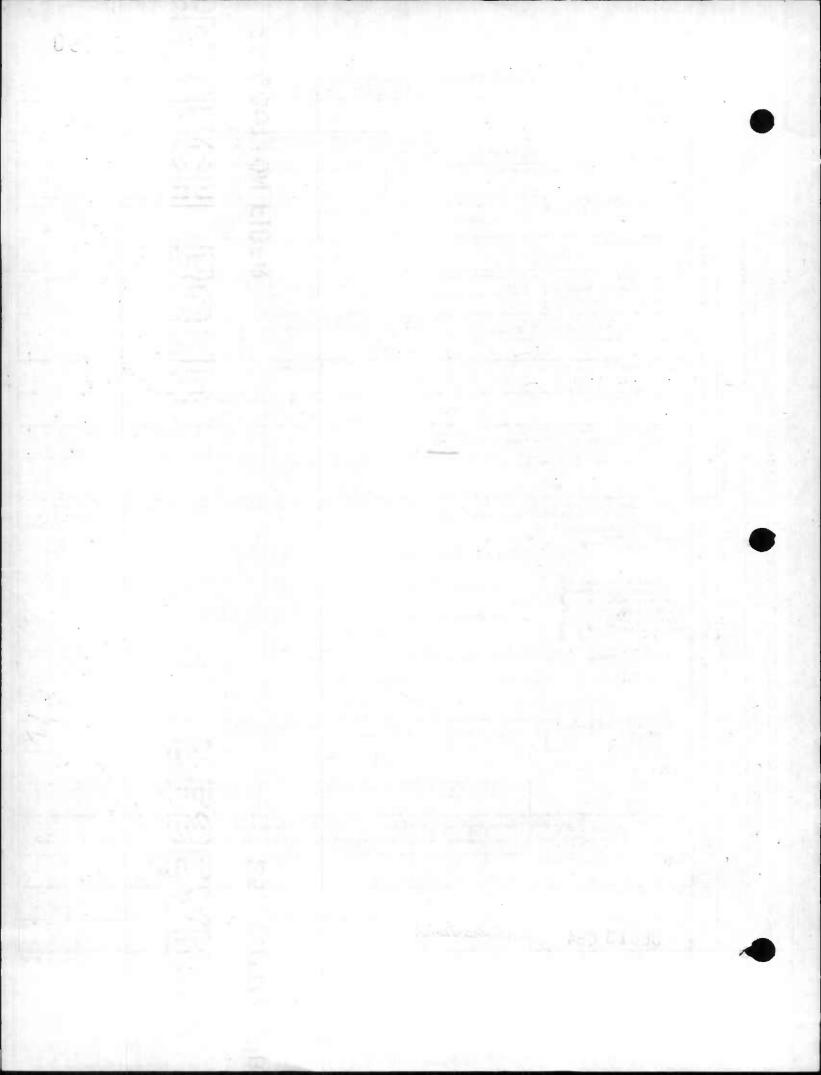
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32. REGISTHAN'S SIGNATURE

DEC 1 3 1994

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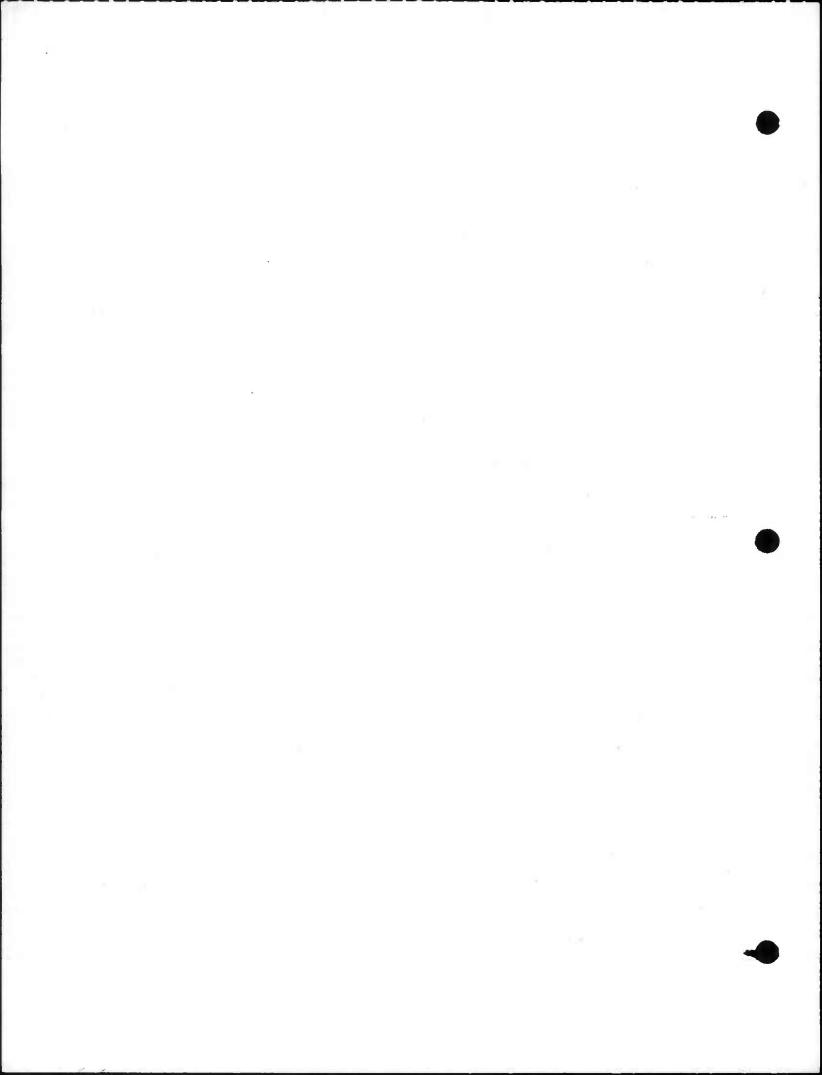


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FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. THE HISHTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. ITANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
2. DATE OF DEATN 3. TIME OF DEATN	1. DECEDENT'S NAME (First, Middle, Last)							
Dec. 10, 1994 9:10 p m	Gerald Brooks Turner, Sr.							
UNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UND							
July 30, 1943 West Virginia	217-40-2993 1X M 2 □ F 51 YRS. MONTH							
DCATION OF DEATH 9c. COUNTY OF DEATH	9a. FACILITY NAME (If not institution, give street and number) 9b. CI							
ton Anne Arundel	457 Oakton Road							
10d. INSIDE CITY	RESIDENCE OF DECEDENT							
nton 1 VES 2 No	Maryland Anne Arundel							
CODE 10g. CITIZEN OF WHAT COUNTRY?	10e. STREET AND NUMBER							
21113 USA	457 Oakton Road							
ENT OF NISPANIC ORIGIN? (Specify Yea or No.— 14. RACE — American Indian, Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc.								
Cuban, Maxican, Puerto Ricen, etc.) NO Specify: Specify:	1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 3 Wildowed 4 Divorced							
Xno specify: Specify: White								
working 16b. KIND OF BUSINESS/INDUSTRY	(Specify only highest grade completed) (Give kind of work don							
Steel Industry	Elementary/Secondary (0-12) 8th Grind							
MOTNER'S NAME (First, Middle, Maiden Surname)	17. FATNER'S NAME (First, Middle, Last)							
Margie Nelson	Erman Hendron Turner							
umber or Rural Route Number, City or Town, State, Zip Code)								
Odenton, MD 21113	Barbara Jean Turner 457 Oakto							
DATE 20c. LOCATION — City or Town, State	20s. METNOD OF DISPOSITION 1							
c. 12/12/94 Baltimore, MD	4 Donetton 5 Other (Specify) Metro Cremato							
ion Society of Maryland, Inc.	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald 2							
ederick Rd. Baltimore, MD 21228	- Curic Tictorara							
of dying, such as cardiec or reepiratory arrest, Approximate interval Between	 PART I. Enter the diseases, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on asch line. 							
Onset and Dasth	IMMEDIATE CAUSE (Fine) disease or condition							
eflux Concer	resulting in dasth)							
me at Sift tresing	DUÈ TO (OR AS A CONSEQUENCE OF):							
1 200 3077 15300	Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):							
The second	csuse. Enter UNDERLYING CAUSE (Disesse or injury							
	that initiated events DUE TO (OR AS A CONSEQUENCE OF):							
	resulting in deeth) LAST							
use given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS	PART II. Other aignificent conditions contributing to deeth but not recuiting in the							
PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
OF DEATH?								
JNCERTAIN 🗆	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES							
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 28. PLACE OF DEATH (Check Check							
Residence 8 - Other (Specify)	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 N							
AT 28d. DESCRIBE NOW INJURY OCCURED	27, MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY							
2 NO	2 Accident Investigation							
281. LOCATION (Street and Number or Rural Route Number, City or Town, State)	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, fi							
	29a. CERTIFIER							
place, and due to the cause(s) and manner as stated. occurred at the time, data and place, and due to the cause(s) and manner as stated.	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my							
	29b. SIGNATURE AND TITLE OF CERTIFIER							
LUGENSE NUMBER 29d. DATE SIGNED (Month, Ogg. Year)	7 Jun 11/2/							
7/9/7	30. MANNE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
Hickory, Glen Durais M. 2/06/	BUSSET QUELUCITY 100 51							
TRINCETTY II THE TOTAL PROPERTY OF THE PROPERT	31. DATE FILED (Month Day Year)							
)	31. DATE TO 3 1994 July 32.0 1932 1883 1894							
the home, (real Duch is 140	31. DATE FILED, Months Day 1947 A July 32. MG(S) DARS GENTLE							





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TYEM: 1. PER F.H. FILM G-718 12/13/94 t.t

1 - STATE OF MARYLAND / D

STATE OF MARYLAND / D

	REGISTRAR		CE	:KIII	ICALE	OF	DEATH	A	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF		NY.	YEAR	3. TIME OF DEATH
	ROBERT NELSON		URNBLAD)				pres	rba	121	994	X:457 H
	4. SOCIAL SECURITY NUMBER	on –	GE (In yrs. las:		IF UNDER	DAYS	IF UNDER 24 HRS.	7. DATE OF E (Month, Da	HTRE		8. BIRTH	IPLACE (State or Foreign
	215-44-1988		18	YRS.				9-8-	46		_	ssachusetts
or l	9a. FACILITY NAME (If not institution, give s				9b. CITY,	TOWN C	OR LOCATION OF O	EATH		9c. COL	JNTY OF D	EATH
DIRECTOR	Greater Baltimor	e Medical (Center		VOL	son				Bal	timo	re
<u> </u>	10a. STATE 10b. COUNT	7		10c. CIT	Y, TOWN O	R LOCAT	TION		_			10d. INSIDE CITY
뚬	Maryland Balt	imore		Co	ckeys	vil	le					LIMITS?
	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	FIZEN OF Y	WHAT COUNTRY?
EB	6 A Lemon Grove	Ct.					21030	U.S.A		.A.		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVI	ER IN U.S. AR	MED			ENDENT OF HISPAI			or No-	14. RACI	E — American Indian, k, White, atc.
ВУ	1 Never Married 2 Amerried 3 Widowed 4 Divorced	FORCES? 1 7		О			ecify Cuban, Maxica 2 X NO Specifi		1, etc.)		Speci	
											Whi	te
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Gr	CEDENT'S ve kind of v Do NOT us	USUAL OC	CUPATIO uring mo	ON st of working	16b. KIN	D OF BUS	SINESS/IN	DUSTRY	
2	Elamentary/Secondary (0-12)	College (1-4 or 5+) 2 yrs		anage				Wood	ting	house	•	
M	17. FATHER'S NAME (First, Middle, Last)	z yrs	1.11	anay	2 T	_	16. MOTHER'S NA			_	е	
	Frank Walter Tur	nblad					Lucill			,		
BE	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS	(Street a	and Number or Rural				in Code)	
2	Sharon Turnblad						Lane Ft					
	20a, METHOD OF OISPOSITION 1 ☑ Burlet 2 ☐ Cremation 3 ☐ Ram		20b. PLACE A	ND DATE	OF DISPOSI	TION /Na		DATE	_		- City or To	wn, State
	1 ← Buriet 2 □ Cremation 3 □ Rem 4 □ Donation 8 □ Other (Specify)	oval from State	Dulane	ery, crematory or other place) Laney Valley			12-15 Timonium, Md.			đ.		
	21. SIGNATURE OF FUNERAL SERVICE LIC			-	22. N	IAME AI	ND ADDRESS OF FA	CILITY				-
	11/	//	1				Towson					4
	23. PART i. Enter the diseeses, or	complications that cau	sed the de	eth. Do n			York Rd					Approximate
	ahock, or heert feilure.	List only one gause o	n eech iine					ii aa sarsias	or respi	ratory at	1000,	interval Between
	iMMEDIATE CAUSE (Final disease or condition	1000		0.00		_ /	San				_	Onset and Death
	resulting in death)	DIVE TO (OR A	AS A CONSEC	UENCE O	ly		100	un	20	M	20	/
z		Arter	ena	01	2	10	Cil	edes	190	100	af h	assular
은	if any, leeding to immediate	disease or condition reculting in death) BNE TO (OR AS A CONSEQUENCE OF): DNE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
2	CAUSE (Disease or Injury	a Du	ela	-2								
Ħ	thet initiated events resulting in death) LAST	DUE TO (OR A	AS A CONSEC	IUENCE OF	F):							1
CERTIFICATION	Constitution of the control of the c	d		-							-	
١	PART II. Other eignificent condition	s contributing to deet	h but not re	euiting i	in the und	derlying	g ceuse given in	Pert i. 24s	. WAS AN		24b	. WERE AUTOPSY FINDINGS
EDICAL								1.0	PERFOR	-	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE
								_ ''	_ TES 2			OF DEATH?
-								_				1 [123 2 [] 110
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINERT						ACE OF DEATH (Ch	eck only one)				
Sic	1 PYES 2 NO	HOSPITAL:	Outpetlant 3	□ DOA	OTHER 4 Nursi		e 5 🗆 Residence	6 Other (Sp	ecify)			
Ě	27. MANNER OF BEATH	28a. OATE OF INJU (Month, Day, Yo.	RY	28b. TIM	E OF URY	28c. INJ	URY AT	28d. DESCRI	BE HOW II	NJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	[,,,,	M		YES 2 NO					
	3 Suicide 6 Could not be	28s. PLACE OF INJ building, atc. (URY — At hou Specify)	me, farm, s	streel, facto	ry, offic		28f. LOCATIO	N (Street a	ind Numbe	er or Rural F	Route Number,
	4 Homicide datarmined								,,			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my k	nowledge, de	nth occurre	d at the tir	ne, deta	and place, and due	to the cause(a) and man	ner aa sta	nted.	
OM	one) 2 MEDICAL EXAMINE	R: On the basis of examin	ation and/or l	nvestigatio	n, In my op	olnion, d	eath occured at the	time, data and	place, and	d dua to t	the cause(s	a) and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIE	1	-	7			29c. LICENSE NUI	ABER		29d. DA	TE SIGNED	(Month, Day, Year)
) BE	Maileston	well	W/X	1						•		
2	30. HAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	DEATH (ITEN	1 27) (Type,	Print)		/		L	2/1	mr	remiziali
	C/OTEF DIL	exxe//M	1)-1	108	846	27	costa.	une	1	1/ 1	Din	Jet HAR
	31. DATE FILED (Month, Day, Year)	32. REDISTRANTS S	GOTURE .	l.		1						
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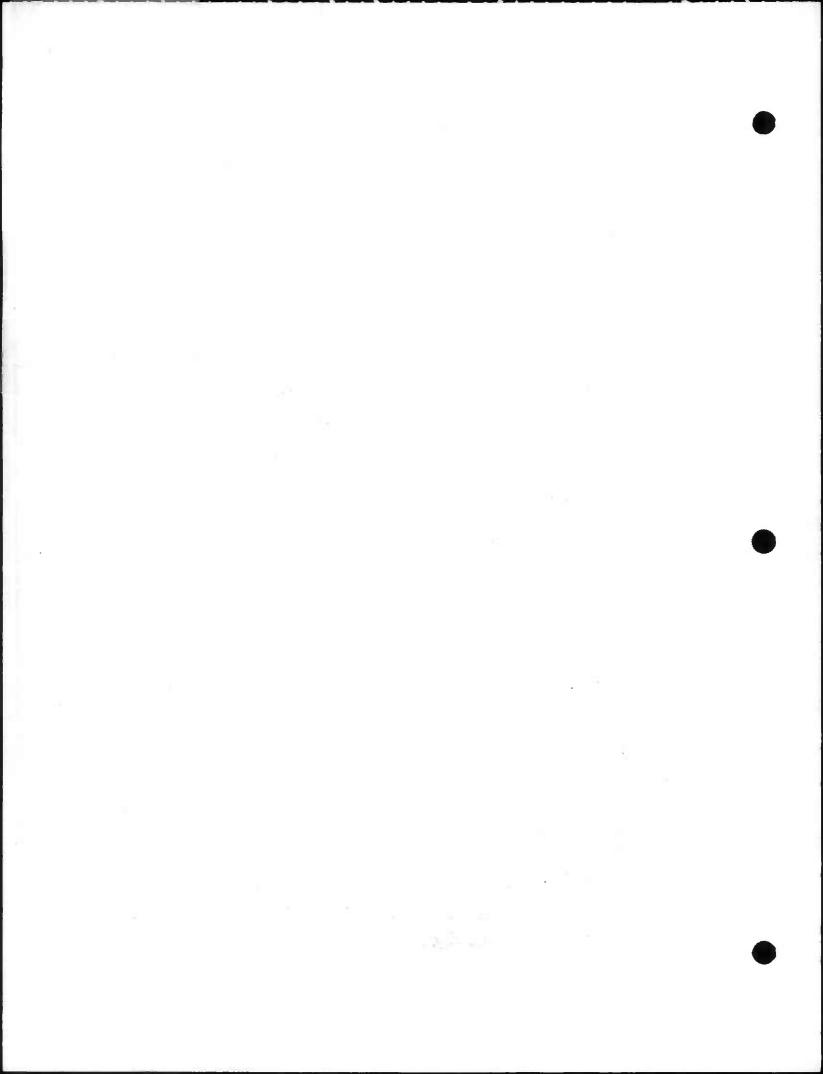
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and within the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR	CERTIF	ICATE C)F DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH			OF DEATH	
	RAYMOND KIEF THOM	PSON			12 10		YEAR (TOA M
		E (In yrs. lest birthday)	IF UNDER 1 YEA	AR IF UNDER 24 HRS.	7. DATE OF BIRTH	- (BIRTHPLACE (SI	tate or Foreign
	216-46-0991 XXM2 🗆 F	78 YRS.	MONTHS DAY	OS HOURS MIN.	(Month, Day, Year) 06-16-	16	Country)	NA MOMA
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOV	VN OR LOCATION OF DE		-	OUTH I	DAKUTA
Œ	KESWICK			LTIMORE		Sc. COOK!	T OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT		DA	DITHORE	CIII			
Ĕ	10s. STATE 10b. COUNTY	10c. CITY	, TOWN OR LO	CATION				DE CITY
늄	MARYLAND		BA	LTIMORE	CITY		VIVI VE	TS? 8 2 NO
	10e, STREET AND NUMBER		1	10f. ZIP CODE	10g. CITIZEN OF WH			
3	700 WEST 40th. STREE	·Т		21211			J.S.A.	
FUNERAL			12 148 6	DECENDENT OF HISPAN	IIO ORIONIO (D II. V.			
II.	11. MARITAL STATUS 1 Never Married 2 Married FORCES? X1X YES	S 2 NO	If yes	, specify Cuban, Mexica	n, Puarto Rican, etc.)	or No —	4. RACE — Americ Black, White, a	tc.
BY	XX Widowed 4 Divorced WORLD WAR OR	II	1 🗆	YES 2X NO Specify			Specify:	
	15. DECEDENT'S EDUCATION	16a. DECEDENT'S	USUAL OCCUP	ATION	18b, KIND OF BU	SIMESS/INDIA	TIHW	E
<u> </u>	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of w	vork done during	most of working	100.74.110	JINE 337 IN D 3.	51111	
7	5 PLUS	PHY	SICIA	N	NE	JROL	SURGE	ON
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden	Cumamal		
	TOLLEF THOMPSON					REYER		
8	19s, INFORMANT'S NAME (Type/Print)	19h MAILING	ACCRESS (Sta	et and Number or Rural F				
입	SANDY LEWIS III	1800						201
- 1		Db. PLACEAND DATE O		HOPKINS 1				201
- 1	1 ☐ Buriel 2/LIXCremation 3 ☐ Removal from State C6	emetary, crematory or of	her place)				ty or Town, Stata	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	REEN MOI		REMATORY E AND ADDRESS OF FAC	12-12 B	ALTO.	,MD.21	202
	0 4 0-				• JENKINS	5 &	SONS	i
	K. M. tsun		49	05 YORK I				1212
	23. PART i. Enter the diseases, or complications that cause	ed the desth. Do n	ot enter tha	mods of dying, auct	n as cardiac or reapi	retory arres	it, Ap	proximats
ŀ	ahock, or heart feliure. List only one cause on iMMEDIATE CAUSE (Finsi	asch iins.						arvai Batween
ı	disease or condition	total	Cola	CA				TO THE STATE OF
- 1	resulting in death)							Month
- [OUE TO (OR AS A CONSEQUENCE OF):							
	OUE TO (OR AS	A CONSEQUENCE OF						
NOI	Sequentially list conditions, b.	A CONSEQUENCE OF):					
CATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING):					
IFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							
RTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	A CONSEQUENCE OF						
CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	A CONSEQUENCE OF):					
3	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to daeth	A CONSEQUENCE OF):	ying csuse given in	Part I, 24s. WAS AN PERFOR			TOPSY FINDINGS E PRIOR TO
3	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	A CONSEQUENCE OF):	ying csuse given in	Part I. 24a, WAS AN PERFOR	MEO?	COMPLET	E PRIOR TO ION DF CAUSE
DICAL CE	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to daeth	A CONSEQUENCE OF):	ying csuse given in	PERFOR	MEO?	AVAILABLE COMPLET OF DEATH	E PRIOR TO ION DF CAUSE
MEDICAL CE	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to daeth	A CONSEQUENCE OF	n the underl	ying csuse given in the state of the state o	PERFOR	MEO?	AVAILABLE COMPLET OF DEATH	E PRIOR TO ION DF CAUSE
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MEDICAL CE	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death UNDERTO (OR AS d. DID TOBACCO USE CONTRIBUTE TO CAUSE (25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1	A CONSEQUENCE OF A CONSEQUENCE OF but not resulting is OF DEATH YE 26. PLACE OF DEAT tpetlent 3 □ DOA 29b. Tilet	S NO H (Check only coor of the R: 4 Nousing is	UNCERTAIN tome 5 Residence INJURY AT	PERFOR	MEO?	AVAILABLI COMPLETI OF DEATH 1 YES	E PRIOR TO ION DF CAUSE
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IO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death UNDERTO (OR AS DUE TO (OR AS d. DUE TO (OR AS DUE TO (OR AS TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS TO (OR AS DUE TO (OR AS DUE TO (OR AS TO (OR AS DUE TO (OR AS DUE TO (OR AS TO (OR AS DUE TO (OR AS TO (OR AS DUE TO (OR AS DUE TO (OR AS TO (OR AS DUE TO (OR AS TO (OR AS TO (OR AS DUE TO (OR AS TO (OR AS TO (OR AS TO (OR AS TO (OR AS TO (OR AS DUE TO (OR AS TO (OR	A CONSEQUENCE OF A CONSEQUENCE OF but not resulting is OF DEATH YE 26. PLACE OF DEAT tipetient 3 DOA 29b. Time INJU Y — At home, ferm, secify) wiedge, death occurre on and/or investigation	n the underly S NO H (Check only of OTHER: A Nursing Is For 28c. M t [Itreet, fectory, c d at the time, c n, in my opinion	UNCERTAIN tome 5 GResidence INJURY AT WORK? YES 2 NO iffice date and place, and due in, death occured at the in-	PERFOR 1 YES 2 6 Other (Specify) 28d. OESCRIBE HOW II 28f. LOCATION (Street & City or Town, State) to the cause(e) and martime, data and place, en	NJURY OCCU	AMAILABLE COMPLET OF DEATH 1 YES REO Rural Route Numb	E PRIOR TO ION OF CAUSE 2 NO Per,
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DIVISION OF VITAL RECORDS, P.O.

completely filled in by the funeral director, page 5 should be detached or removal. cremation, prior to burial, and signed by the attending physician Health and Mental Hygiene prior to After DIRECTOR: A hours after d THE FUNERAL D filed within 72 h TO THE FUNERAL be filed within 72 IMPORTANT: II 뿐 5

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) -30-94 3. TIME OF DEATH 2. DATE OF DEATH HORK ARRY 100 30 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F MONTHS DAYS HOURS MIN. YRS. 579 88 8866 33 6-2-1961 DC Wash 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince George County Hospital Cheverly Prince George Co Pages 1, 2, 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Landover 1 YES 2 NO Dermit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1256 Capitol View Drive for use as the burial-transit 20785 USA hospital or attending physician. ti. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc. Specify: Black IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) the at Page 6 may be retained by BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Buriel 2 Cremetion 3 Removal from State removal 4 Donetton 5 Other (Specify) in State 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.Baltimore St, Balto, MD21201 after medical 23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximste shock, or haart failure. List pnly one cause on each line. intarval Between MMEDIATE CAUSE (Final Onset and Daath the acquired immune deficiones disesse or condition ne executed within event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequantially list conditions, DUE TO JOB AS A CONSEQUENCE OF if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury requires that the death certificate be or other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO this certificate has been with the State Dept. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DR ATTENDING PHYSICIAN: The law Item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: VES 2 NO 1 | Inpatient 2 | R/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 5 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending 1 YES 2 NO ВУ Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28 15 8 Could not be determined after n COMPLETED 4 - Homicide Item 29e. CERTIFIER 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner as stated. HOSPITAL 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

REGISTRAN'S SIGNATURE

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

WHITE

WICK

1 YES 2 NO

MD.

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

OF DEATH?

Interval Between

Onset and Death

MARYLAND

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

N/A

REG. NO.

2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Rosalie Estelle Wade

BALTIMORE, MARYLAND 21215-0020

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DIVISION	the second of the second of the second of the second of
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4. SOCIAL SECURITY NUMBER 5. SEX last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 3104 Day 1 24) 1 🗌 M 2 💟 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH HARBOR HO DIRECTOR Pages 1, 2, 3 HARBOR HOSPITAL CENTER BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND N/A BALTIMORE permit. F 10e. STREET AND NUMBER FUNERAL CHRIST CHURCH HARBOR APARTMENTS 101. ZIP CODE 600 LIGHT STREET 21230 burial-transit APT. 418 fours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMER FORCES? 1 YES 2 HO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 1 NeverMarried 2 Married It yes, specify Cuban Mexican, Puerto Rican, etc.)

1 YES 2 P NO Specify: BY 3 Widowed 4 Divorced funeral director, page 5 should be detached for use as the COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)
N/A Elementary/Secondary (0-12) ACCOUNTANT LEATHER GOODS 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Sumame) notified at **GEORGE ECKHARDT** TINA BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GARY L. WADE 566 DURHAM ROAD, MADISON, CT. 06443 ě 20a METHOD OF DISPOSITION
1 D Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 12/12 CEDAR" HILLO CEMETERY 1994 BROOKLYN PARK, 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND and completely filled in by the or removal medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) CARDIOGENIC SHOCK event, burial, VENTRICULAR FAILURE traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate attending physician that the death certificate be prior cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 signed by the atten Health and Mental I PART ii. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any Health 1 YES 2 NO Shows 0 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOLCERTAIN Dept 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The State this certificate HOSBITAL: OTHER: 1 YES 2 NO atient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the or 27. MANNED OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED with marked, 1 Natural 5 Pending DIRECTOR: After the hours after death was ВУ 1 YES 2 ND 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) after de 3 Suictde 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT; If Item 2 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examinetion and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Pear) 29c. LICENSE NUMBER BE M.T 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. NAME AND ADDRESS OF PERSON

DHMH-16 Rev 1/89

Amen this ce TO THE HOSPITML OF ATTENDING TO THE FLINERAL DIRECTOR: A People of the Million of August after Original IMPORTANT. IN Heliter 2011 in

to respect of attending proportion.	be detached for use as the burial-transit permit. Pages 1, 2, 3 should	at once.
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-	ge 5 sh	or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
2	letely filled in by the funeral director, page 5 sh	Trust b
3	eral dire	niner
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	ertificate has	r iten
	P 4	0

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)				<u> </u>	2. DATE OF DEATH		3. TIME OF DEATH	
	EARL WESS	SELS WOOLFORD			MONTH DAY YEAR				
				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIR	THPLACE (State or Foreign	
	213-05-9136 1XXM 2 F		33 YRS.	NTHS DAYS	HOURS MIN.	02-13-191		TRYLAND	
R	MERIDIAN NURSIN		90		RNA PAR		9c. COUNTY OF	E ARUNDEL	
CTC	RESIDENCE OF DECEDENT				CIVIA Z ZAT		ANN	AKONDU	
DIRECTOR	MARYLAND ANNE	ARUNDEL		GLEN	BURNIE			10d. INSIDE CITY LIMITS? 1 TYES 2 THE	
	10a. STREET AND NUMBER			10f. ZIP CODE				WHAT COUNTRY?	
FUNERAL	307 7TH AVENUE	, N.E.			21060)	U.S	. A .	
5	· ·	2. WAS DECEDENT EVER IN 1 PORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	NC ORIGIN? (Specify Yea n, Puerto Ricen, etc.)	or No — 14. RA	CE — Americen Indian, ick, While, atc.	
ΒY	1 Never Merried 2 Merried 3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 NO Specify		100	ochy: WHITE	
	15. DECEDENT'S EDUCAT	TION	18e. DECEDENT'S USL	IAL OCCUPATION	IN .	16b. KIND OF BUS	SINESS/INDUSTRY	***************************************	
	(Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re-	done durina moi	st of working		SINCE OF INTEREST OF THE		
COMPLETED		N/A	SALES	_		A	UTO		
	17. FATHER'S NAME (First, Middle, Last) EDGAR	WOOLFOR	מא	_		ME (First, Middle, Maiden ENCE		WESSELS	
BE	19e. INFORMANT'S NAME (Type/Print)	WOODI OI						WESSELS	
2		COREY				ASADENA		1122	
	20e. METHOD OF DISPOSITION	20b. F	PLACE AND DATE OF D	SPOSITION /Na	me of 12/	1 5060E/1 20c. LO			
	1 DeBuriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	I Irom State came!	EN HAVE	N MEN	ORIAL	PK GI		RNIE, MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICEN		+		D ADDRESS OF FAC		TON FU	NERAL HOME	
	//chack (Sall	(Du)	1 SEC	OND AV	ENUE, S. MD. 210	W .		
	23. PART I. Enter the disesses, or con ahock, or heart fallure. Lis	nplications that caused to only one cause on ear	the death. Do not	enter the mo	de of dying, auct	n as cardiac or reapl	ratory arrest,	Approximate interval Between	
	iMMEDIATE CAUSE (Finsi disease or condition	north		0		1		Onset and Death	
	resulting in death)	ACO (E	RAS A CONSEQUENCE OF:						
_		AN STERIC	S A CONSEQUENCE OF):			DICOVAS	eval		
ē	Sequentisity ilst conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):	0110		DICE	ASIF		
CA	cause. Enter UNDERLYING CAUSE (Disease or injury					- (- (0		
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):						
ä	d								
AL	PART ii. Other significant conditions of	ontributing to death but	t not resulting in th	ne underlying	cause given in	Part i. 24s. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
9						1 YES 2	LNO	COMPLETION OF CAUSE DF DEATH?	
Σ	DID TOP ACCO LICE CONTRUE	NITE TO CALICE OF	DEATH VEC					1 TES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERTAIN	<u> </u>			
SICI	EXAMINER?	IOSPITAL:	01	HER:	5 🗆 Residence	• 🗆 • • • • • • • • • • • • • • • • • •			
Ä	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	26c. INJU	JRY AT	28d. DESCRIBE HOW II	NJURY OCCURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 Y	RK? ES 2 NO				
	3 Suicide 6 Could not be	26s. PLACE OF INJURY building, etc. (Specify	- At home, lerm, stree	t, fectory, office		28I. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)			
	4 Homicide datarmined			_					
COMPLETED		N: To the best of my knowled							
Ō	2 MEDICAL EXAMINER: (In the basis of examination of	end/or investigation, in	my opinion, de				2	
H	290 SIGNATURE AND TITLE OF CERTIFIER	ATTENDIA	26		29th LICENSE NUM	G	29d. DATE BIGNE	Q (Morris Day Meer)	
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Prin	0	2411	O	-	110	
	SURYAP-MU	NORA MO	1600		TUH	#106 6	SENBU	MIE 2106	
	31. DATE FILED (Month, Day, Year) DFC1 3 1994	32, REGISTRAR'S SIGNAT	II.		,				

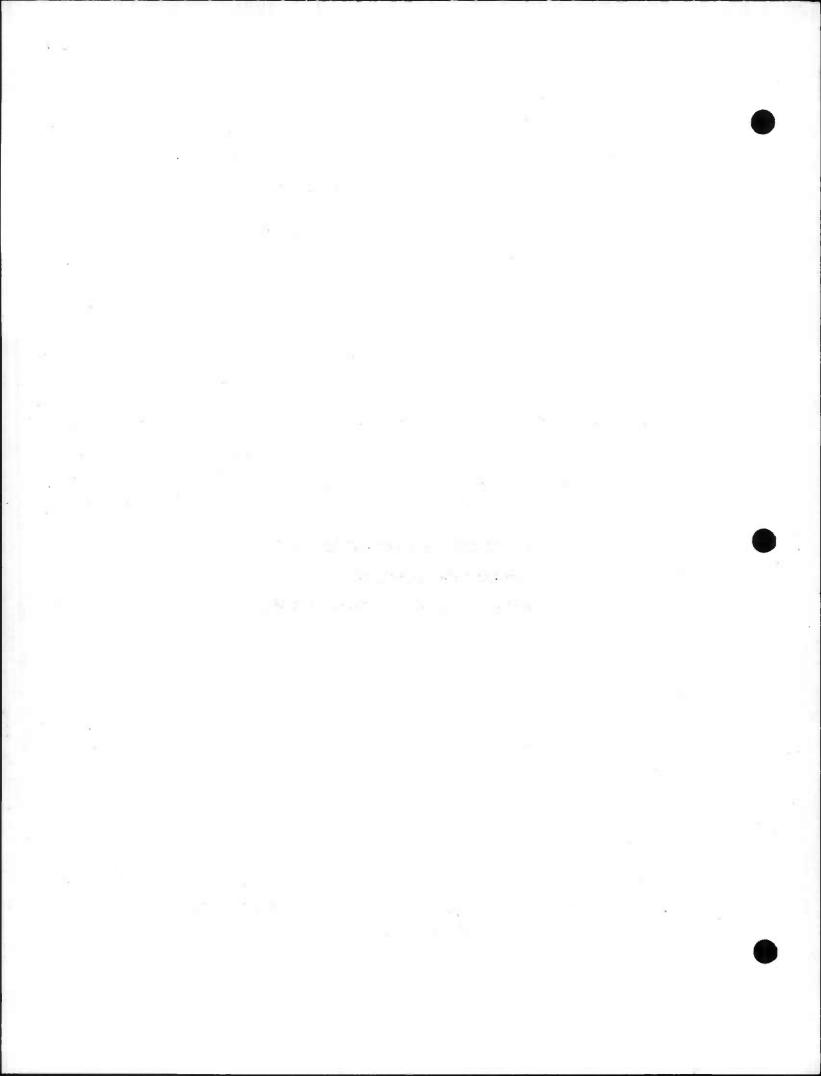
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WISION OF VITAL RECORDS, P.O. BOX 68/60. BALTIMORE, MARYLAND 21215-0020	THE MONEY OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with shours after death. Page 6 may be retained by the hospital or attending physician.	THE FLIMENCE FETORS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.	The second state death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT II Ian 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
5	PHYSICI	this cert	with the	rked, o
20	DING F	After	death	s mar
2	ATTEN	ECTOR	s after	1 28
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•	#	-	Kell	PORT
	18	9	98	2

FOR										
1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	STATE OF MA	ARYLAND / DEPA CERTI					REG. NO	_		
ANNA	KATHRYN	WA	LTER				2. DATE OF DEATH	°199	4 YEAR	7:00 am
4. SOCIAL SECURITY NUMBER 212-03-0141	5. SEX 1 M 2 X F	i. AGE (In yrs. last birthday 84 YRS.	MONTHS	-	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 7, 1	910	8. BIRTH Countr	Maryland
9a. FACILITY NAME (If not institution, give s Saint Joseph Hosp			9b. CITY	Town on			ATH	9c. COL	Baltir	EATH
Maryland	1	10c. C	EITY, TOWN (1020	City			10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER	NO Looknow	Dood		_	ZIP CODI	E				t X YES 2 NO
11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT FORCES? 1	YES 2 X NO	13.	If yes, spec	Ify Cube	F HISPAN	1239 IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)		14. RACE	States - American Indian, k, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAI			1 TYES 2		Specify			Speci	White
15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	IIIe. Do NOT	of work done use retired.)	during most		ng .	16b. KIND OF BU	SINESS/IN	DUSTRY	
17. FATHER'S NAME (First, Middle, Last)	Leo Hick	ey			18. MOTH	IER'S NA	ME (First, Middle, Meiden Rose M.		r	
to. INFORMANT'S NAME (Type/Print) Harry D. Walt	er		OS LO				Apt. B B			, Md. 2123
20e. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		20b. PLACE AND DAT cemetery, cremetory or	EOF DISPOS	ITION (Nem	e of		DATE 20c. LO	CATION -	City or To	
21. SIGNATURE OF FUNERAL SERVICE LIC	Milton	Gardens J Knight	Jr 22.	NAME AND	ADDRES	SS OF FA	Leonar	dJ.		, Inc.
Sequentielly liet conditions, if any, leading to immediate	ACUTE O DUE TO (O DUE TO (O DUE TO (O ARTERIO	Pused the deeth. Do Do each line. EREBROVAS IR AS A CONSEQUENCE C CARDIOM IR AS A CONSEQUENCE SCLEROTIC IR AS A CONSEQUENCE	OF): YOPAT	R ACC	CIDE	VT		iratory a	rest,	Approximate interval Betwee Onaet and Dea
PART II. Other eignificent condition	s contributing to d	eeth but not resulting	g in the un	nderlying	Ceuse ç	jiven in	Part I. 24a. WAS AN PERFOF	RMED?	246	WERE AUTOPSY FINDIN AMAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
27. MANNER DF DEATH 1 Naturel 5 Pending 2 Accident Investigation	1 Supplient 2 ER/Outpetlent 3 DOA 4 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME INJURY			28c. INJUI WOR	RY AT		a C Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED			
3 Suicide a Could not be detarmined	28s. PLACE OF building, et	NJURY — A1 home, ferm c. (Specify)	, street, fect	ory, office			28f. LOCATION (Street City or Town, State)	and Numbe	er or Rural F	Route Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE		y knowledge, desth occu minetion end/or investige) end manner as stated.
296. SKISNATURE AND TITLE OF CERTIFIES		-000d, C	04		29c. LICE	NSE NUM	ABER	29d. DA	E SIGNED	(Month, Day Year)
30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITEM 27) (Ty)	pe, Print)	DAL	TIME)DE	MD 21224	(11	VI

July 3 A RECISTRAR'S SCHALLER

DECT 3 1994



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

The function After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. ours after death. Page 6 may be retained by the hospital or attending physician. ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE HOSPI TO THE FUNCH THE RING WITHIN

is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

29e. CERTIFIER

TO BE C

MEDICAL EXAMINER: On the basis

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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF H		ENTAL HYGIENE REG. NO.	E	
TOR	1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 220-40-7806 90. FACILITY NAME (If not institution, give stree Falls to Law (a)	UNKIN Winde 5. SEX 6. AGE (In yrs. last 1 X M 2 F	OSC., birthday) IF UNDER t YEAR YRS. MONTHS DAYS		2. DATE OF DEATH DAY DEC. 5 O O O O O O O O O O O O O O O O O O	9 9	ETHPLACE (State or Foreign unitry)
FUNERAL DIRECTOR	RESIDENCE OF DECEMENT 10e, STATE 10b, COUNTY MANUAN 10e, STREET AND NUMBER 1717 TUdy W	40. Co		1000 1. ZIP CODE 21040		10g. CITIZEN O	10d. INSIDE CITY LIMITS? 1 YES 2 NO F WHAT COUNTRY?
B	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 ☐ YES 2 YENC IF YES, GIVE WAR OR DATES	O It yee, sp. 1 _ YES	ecify Cuben, Mexicen, 2 NO Specify:		Sp	ACE — American Indian, lack, White, etc.
COMPLETED		impleted) (Givi	EDENT'S USUAL OCCUPATION OF KIND OF WORK done during mo Do NOT use retired.)	ON six of working	16b. KIND OF BUSI	NESS/INDUSTRY	
TO BE CO	17. FATHER'S NAME (First, Middle, Last) 190. INFORMANTIS NAME (Type/Print)	INDER 196	MAILING ADDRESS (Street a	MELI	E (First, Middle, Melden S WSA U ute Number, City or Town	INGE	Edgenos,
	20s. METHOD OF DISPOSITION Burlel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNETIAL SERVICE LIGHT	al from State cemetery, gem	ND DATE OF DISPOSITION (Na net approving piece)	IND ADDRESS OF FACE	DATE, 20c. LOC DATE, 20c. LOC DATE, 20c. LOC	TIE UI	Town, State ASSH LL
ION	23. PART i. Effer the diseasea, pr con ahock, pr heert fallure. Lis immediate CAUSE (Final disease pr condition reaulting in death) Sequentially list conditions, if any, leading to immediate	mplications that caused the deast only one cause on each line. DUE TO (OR AS A CONSECUENCE OF AS A CONSEC	And list	de of dying, auch	aa cardiac or reapir	VE.	Approximate interval Between Onset and Death
CEMINICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEOL	JENCE OF):				
MEDICAL	PART II. Other algorificant conditions of the property of the	ension			PERFORM 1 YES 29	MED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
HYSICIAN:	1 YES 2 NO 1	OSPITAL: Inpetient 2 ER/Outpetient 3		5 Fresidence 8	Other (Specify)		
BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28e. PLACE OF INJURY — At hom	M 1 🗆 Y	RK? /ES 2 NO	ed. DESCRIBE HDW IN.		al Route Number,
et 18	A P ANNIA IN DA	building, etc. (Specify)			City or Town Steams		

O COMPLETED CALLE OF DEATH (ITEM 27) (Type, Print) DECT 3 1994 REGISTRATI SIGNATURE

1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

In my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated,

29d. DATE SIGNED (Month, Day)

29c. LICENSE NUMBER

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		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) CLARENCE		NILLE	=/		2. DATE OF DEATH	7 95	3. TIME OF DEATH 2. SA M
should	_	4. SOCIAL SECURITY NUMBER 213 - 18 - 5757 9a. FACILITY NAME (If not institution, give st	1 ØM 2 □ F	(In yrs. last birthdey) 8 C YRS.	MONTHS DAYS 9b. CITY, TOWN	HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) 5 - 2 5		BIRTHPLACE (State or Foreign Country) MARYLAND OF DEATH
1, 2, 3	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Nursing Hom		Y, TOWN OR LOCA				I and INDEPENTATION
permit. Pages	AL DIR	Maryland Dorc	hester			Vienna	1	10g. CITIZEI	fod, INSIDE CITY LIMITS? 1 YES 2 NO N OF WHAT COUNTRY?
iian. transit	UNER	Market Street 11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED	13. WAS DE	2186	9 HC ORIGIN? (Specify Ye	U	ISA
700	A	1 Never Married 2 Married 3 Wildowed 4 NDIvorced	FORCES? 1 X YES	2 NO ATES	If yes, sp		n, Puerto Ricen, etc.)		Specify: White
THE PARTY OF THE P	PLETER	15. DECEDENT'S EDUC (Specify only highest grade of the content of	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT us OWne	vork done during me e retired.)	ON ost of working	Service		
YLAND I by the house d be detached	E cón	17. FATHER'S NAME (First, Middle, List) John Aude:	r Willey			18. MOTHER'S NA	ME (First, Middle, Maider Sallie H		
E, MARYI y be retained by sage 5 should be be notified al	TO B	Patricia T. Loi	mbardo				Route Number, City or Too t Baltin	nore,	MD 21202
CE TE		20e. METHOD QF DISPOSITION 1	val from Stata		matory	, Inc. 1	12/12/94		more, MD
		- Jama7	namal	McDonal	Crem	Frederi	ociety o	Baltim	yland, Inc. ore, MD 2122
tely filled in by mation, or remo	100	23. PART I. Enter the diseases, or c ehock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Preumo	ach line.	ot enter the mo	ode of dying, suc	h ss cerdiac or reap	iretory screst	Approximete Interval Between Onset and Death 2 4 Hears
S, P.O. BOX 68760, death certificate be executed within attending physician and complete ental Hygiene prior to burial, cremaint, or other traumatic event,	CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE DE	·):				
RECORD; requires that the been signed by the ft. of Health and M shows any injection.	MEDICAL	PART, II. Other algoriticant conditions Cerebrae Was Sfugke DID TOBACCO USE CONTR	ienlar d	isease	and p	lucir	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
The The ate to me	'SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Oulp	28. PLACE OF DEAT	QTAER:	ne 5 🗆 Rasidenca	6 Other (Specify)		
OF PHYSIC this cer with th	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	URY WO	URY AT DRK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	IEO
TISIC NTTENDI CTOR: A after de	0	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, ferm, a	trest, factory, offic	•	28f. LOCATION (Street City or Town, State		Rural Route Number,
= 2 ½ ½	COMPLETE		CIAN: To the best of my knowl t: On the beels of examination						ause(a) and manner as stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	O BE	296. SIGNATURE AND TITLE OF CERTIFIER W. Jealelle 7	re grego	zhd.		29c. LICENSE NUN	7	Dece	IGNED (Month, Day, Year) Wher 12, 1994
241		10. IRABETTE RAC	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, KESWIC	Print) K,700	W-404	LSTREET	BALTE	17021211
	{ F	31. DATE FILED (Month, Day, Year) 1994	32. REGISTRAN SIGN	ATURE A TOTAL	6				

BALTIMORE, MARYLAND 21215-0020

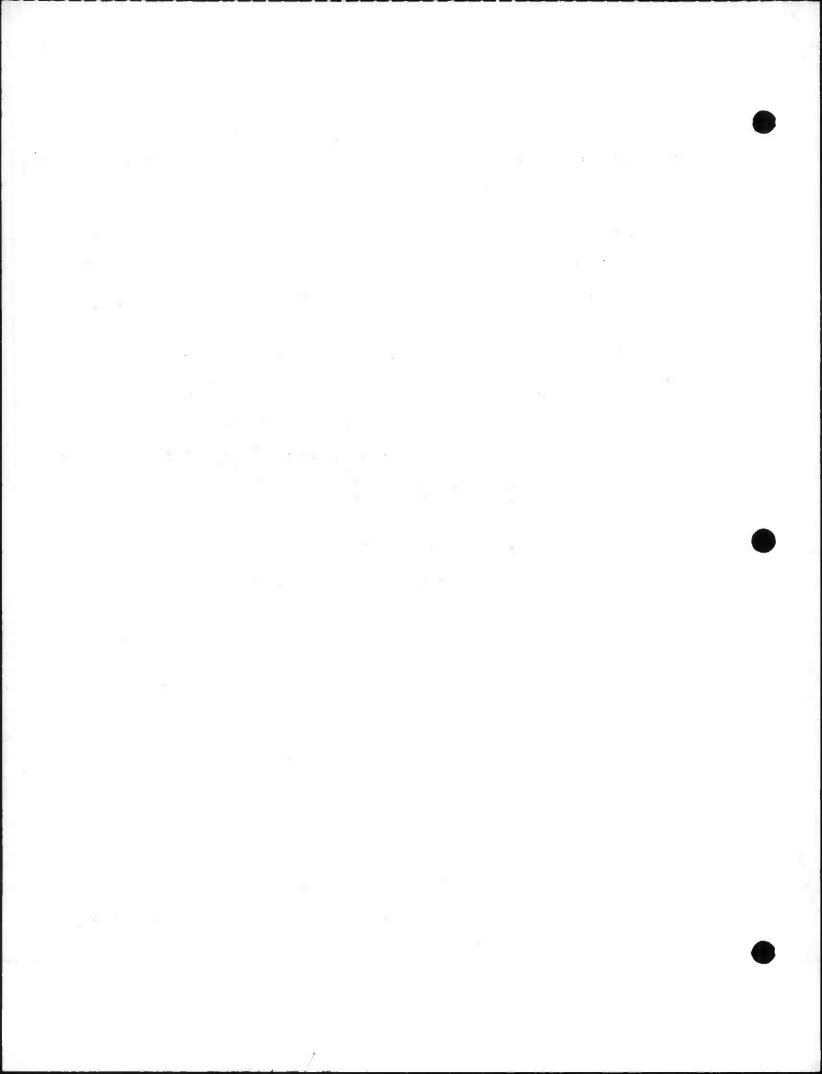
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a viour after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	-	FOR STATE REGISTR	AR
	1. D	ECEDENT'S	NAM

	REGISTRAR CERTIFICATE OF DEATH REG. NO.								
- 1	1. DECEDENT'S NAME (First, Middle, Lust) NOSES C, Wims 2. DATE OF DEATH NONTH DEC TAY 19951								
тов	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 8. AGE (In yrs. lest birthday) 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 3 F 1 M 2 F 1 M 3 F 1 M 4 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M								
	98. FACILITY NAME (If not institution, give street and number) 3519 Robb Street RESIDENCE OF DECEDENT. 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH								
DIRECTOR	10d. INSIDE CITY WATY AND 10b. COUNTY 10c. CITY, TOWN OR LOCATION Ball more 10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{NO}\) NO								
FUNERAL	2617 Rubb Street 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 21218 USA								
BY FUI	11. MARITAL STATUS 1 Never Married 2 Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—Black, White, etc.) 16. RACE — American Indian, Black, White, etc.								
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) Rubber Cutter factory								
BE CO	17. EATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Moother								
10 B	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25.1780hb St. Botto 11d 21018								
	20e. METHOD OF DISPOSITION 1 O' Burlet 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Capture), or finatoly or other play 1 or oth								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 25 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 26 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 27 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 28 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 29 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 29 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 21 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 29 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 20 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 20 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 21 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 21 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 22 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 25 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 26 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 27 NAME AND ADDRESS OF FACILITY RUSS FUNERAL HIM 28 NAME AND ADDRESS FUNERAL HIM								
	23. First the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart fellurs. List only one cause on each line.								
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Response of the condition resulting in death)								
Z	DUE TO (OR AS A CONSEMUENCE OF): Sequentially list conditions Description Property Property Cancer Property								
CATIO	ti any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST								
- 11	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS								
EDICAL	PERFORMED? 1 YES 2 ON COMPLETION OF CAUSE DF DEATH?								
M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
PHYSICIAN: M	28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? OTMED: OTMED:								
HYS	1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home Residence 8 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY 28. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED								
ВУБ	Netural 5 Panding (Month, Dey. Year) NJURY WORK? 1 YES 2 NO								
ETED	3 Suicide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, streel, fectory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, ferm, streel, fectory, office City or Town, State)								
COMPLETED	29a. CERTIFIER (Check only one) 29 LERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated. 29 LERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated.								
₩	196. SIGNATURE AND TITLE OF CHAPTER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 12 14 18 19								
임	10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STAN WAS TEN M. B. UNION Manon of Italy Age I man men mon.								
	31. DATE EILED (Month, Dev. Year) 32. REGISTRAR'S SIGNATURE								
	DECI 31994 July Davelson Revolt								



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	hoval.	cal examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITATE AND THE INVESTIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. Are this certificate has been signed by the attending physician and completely filled in b.	be filed within 72 now with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il tem 28 ts marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / D CEF	EPARTMENT OF H	EALTH AND	MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH			
	GEORGE GR. 4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last bi	VAQNER Inthosyl F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1994				
-	214-26-5645 18 M 2 F 65 VRS. MONTHS DAYS HOURS MIN. (Morth, Day, Year)									
STOR	98. FACILITY NAME (If not institution, give street and number) FRANKLIN Woods Meridian Rosedale BATTIMORE RESIDENCE OF DECEDENT									
DIRECTOR	MARYLAND BAL	TIMORE	FSSBB	ION C			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER	908	101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
FUNE	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARME- FORCES? 1 YES 2 NO			NIC ORIGIN? (Specify)	'aa or No — 14.	RACE — American Indian, Black, White, etc.			
В	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 🗆 YES				specity: white			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give I	DENT'S USUAL OCCUPATION kind of work done during most NOT use retired.)		16b. KIND OF E	USINESS/INDUST	RY .			
JAWC	17. FATHER'S NAME (First, Middle, Last)	3 Me	dical le	Chric	ME (First, Middle, Maide	Spita	4/			
BE C	GEORGE GR	: AA: th WAS	NEC	MIL	lic	We	ERNER			
2	JOYCE E. J. W	AGNER MA	AATEN ROAD	908	Route Number, City or To	wn, State, Zip Cod)))			
	20a. METHOD OF OISPOSITION 1	oval from Stata cemetery, cremat	DATE OF DISPOSITION (Na. tory or other place)	me of	OATE 20c. I	OCATION — City	or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LIC			D ADDRESS OF FA		ALLIMO	FUDA			
	Mark a	Chamach	1005/	brows,	16 AVE	Ralta	H/21224			
	23. PART i. Enter the diseases, or shock, or heert feliure.	complications that caused the death List only one cause on each line.	n. Do not enter the mo	de of dyling, suc	h es cerdiac or ree	piratory arrest,	Approximate interval Batween			
	IMMEDIATE CAUSE (Final disease or condition reaulting in death)	Metastatio	e Carcin	10ma E	20A 10	tate	Onset and Death			
	Todaking wir dodality	DUE TO (OR AS A CONSEQUE			0		- 1913			
CERTIFICATION	Sequentially list conditions, it any, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A CONSEQUE	ENCE OF):							
IFIC	CAUSE (Disease or Injury that initiated eventa	OUE TO (OR AS A CONSEQUE	ENCE OF):							
CER	resulting in death) LAST	d								
CAL	PART II. Other significant condition	e contributing to death but not reeu	ulting in the underlying	cauae given in		N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
PHYSICIAN: MEDIC					t 🗆 YES	2 MNO	OF DEATH?			
AN:	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH		UNCERTAIL	N 🗆					
SICI	EXAMINER?	HOSPITAL: 1 Inputiant 2 ER/Outputient 3	OTHER:	S □ Besidense	8 Other (Specify)					
Ή	27. MANNER OF OEATH		8b. TIME OF 28c. INJI		28d. DESCRIBE HOW	INJURY OCCURE	ED			
BY I	t Natural 5 Pending 2 Accident Investigation		M t 🗆 Y	ES 2 NO						
TED	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY — At home, building, atc. (Specify)	, term, street, factory, office		26t. LOCATION (Stree City or Town, Stat		ural Route Number,			
COMPLETED		CIAN: To the best of my knowledge, dasth R: On the basis of examination end/or inve					use(e) and manner as stated.			
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	- 444		29c. LICENSE NUM	MBER	29d. DATE SIG	GNED (Month, Day, Year)			
0	30. NAME ANO ADDRESS OF PERSON WH	O COMPLETED CAUSE OF OEATH (ITEM 2)	7) (Type, Print)	0085	75	De	c. 12,1994			
	William Ha	KKARINEN M.I	D. 9000 FR.	auklin S	guare L	DR BALL	4. Md. 21237			
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1, 2, 3 should	ECTOR	FOREST Haven Malsing Home BAltimore Baltimore Count	7								
ermit. Pages	AL DIRE	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES NO 10c. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?	,								
physician. burial-transit permit.	FUNER/	135 In 9/e Side Acesice 2 2 3 2 8 USA 11. MARITAL STATUS 1 Never Married 2 Married PORCES? 1 YES 2 NO 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— Black, White, etc.) 1 Never Married 2 Married Black, White, etc.									
as the	ED BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 THO Specify: Specif	Œ								
for u	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) 12+h NONE (Give kind of work done during most of working life, Do NOT use retired.) NONE NONE									
	BE CO	17. FATHER'S NAME (First, Middle, Last) WILSON GILMORE 18. MOTHER'S NAME (First, Middle, Maiden Surneme) PATIENCE COTTON 190. INFORMANT'S NAME (First, Middle, Maiden Surneme) 190. MAIL INC. ADDRESS (Street and Number of Run Surneme) 190. Wall INC. ADDRESS (Street and Number of Run Surneme)									
ay be retained by page 5 should be be notified at	2	IRENE MC QUAY 3 Wickham Ct. Reisterstown, Md. 21136									
ce nouts are ceam. Page 6 may be filled in by the funeral director, page on, or removal.		206. METHOD OF DISPOSITION 1 Suries 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other piece) BALTIMORE CEMETERY 12/15/94 BALTO, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CATIVIN D. SCRUICCE, FILINGED A. HOME.									
d in by the fun or removal.	CALVIN B. SCRUGGS FUNERAL HOLD 1412 E. PRESTON ST. BALTO, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest,										
ompletely al, cremati event, tl		shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Betw Onset and D DUE TO (OR AS A CONSEQUENCE OF):	тееп								
ysician and prior to but traumati	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST									
signed by the Health and Me	MEDICAL	PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. IRANSIENT TS CHAEMIC ATTACKS. 1 YES 2 MO OF DEATH? 1 YES 2 NO.									
ertificate has been the State Dept. of or Item 23 she	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Af Nursing Home 5 Residence 8 Other (Specific)									
with with	ву рну	1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA Warring Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO NO NO NO NO NO NO									
ifter death	ETED B	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
22	OMPE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	d.								
TO THE PORT	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED CHIEF CHIEF HINTY 296. LICENSE NUMBER DATE SIGNED CHIEF CHIEF HINTY 296. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
		1220 PARK HEICHTS AVE PACTO MD 21205, TASKETM CAKHA	m								
, [DECT 9 1334 June									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	A. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach	Thours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.	III item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	K	N.	2	=

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		TMENT OF H		MENTAL HYGIEN				
		WILLIAW	15 (RONNIE V	VILLIAMS	2. DATE OF DEATH MONTH DECEMBET	4 198	3. TIME OF DEATH		
	233-88-5598	SEX 6. AGE (In yrs, le	ast birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Monthy Day, War)	_	BIRTHPLACE (State or Foreign Country) RLANDO, FL		
TOR	9a. FACILITY NAME (If not institution, give street WASHINGTON COUNTY RESIDENCE OF DECEMENT				RSTOWN	EATH	9c. COUNTY WASHI			
DIRECTOR	10a. STATE 10b. COUNTY	ERSON		Y, TOWN OR LOCAT		· · · · · · · · · · · · · · · · · · ·		10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER ROUTE 3, BOX 340			101	25430			N OF WHAT COUNTRY?		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES	RMED NO	If yea, sp	ENDENT OF HISPAT ecify Cuben, Maxica 2 X NO Specifi	NIC ORIGIN? (Specify Yen, Puarto Rican, stc.)	s or No 14	. RACE — American Indian, Black, White, etc. Specify: BLACK		
COMPLETED		npleted) (1 College (1-4 or 5 +)	Give kind of le. Do NOT u	,	ON st of working		16b. KIND OF BUSINESS/INDUSTRY			
OMF	10 17. FATHER'S NAME (First, Middle, Last)		RUCK	DRIVER	16. MOTHER'S NA	D. M. ME (First, Middle, Maider		TRUCKING		
BE	WILLIE G. ANTHONY 190. INFORMANT'S NAME (Type/Print)		Ob. MAH INC	ADDRESS (Complete	CLARIC	CE WILLIAM	S			
٩	MRS. LILLIAN WILLIAMS ROUTE 3, BOX 340, KEARNEYSVILLE, WV 25430									
	28e. METHOD OF DISPOSITION 1 ← Burisi 2 ← Cremation 3 ← Removal 4 ← Donation 5 ← Other (Specify)	from State 20b. PLACE cometery, or LAKE	ematory or o	of oisposition (Ne ther place) CEMETEF	me of	12/10 LA		er Town, Stata ES, FLORIDA		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Brown		BROWN		HOME, 32		ING STREET 25401		
	23. PART I. Enter the diseases, or com- shock, or heart fellure. List IMMEDIATE CAUSE (Final	nplications that caused the d t only one cause on each lin	leath. Do i					Approximate Interval Batwean Onsat and Death		
	23. PART 1. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximatintarval Bat onset and disease or condition resulting in death) Out TO (OP AS A CONSEQUENCE OF): Sequentially list conditions, out the conditions of the condi									
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CATIC	oue to (or as a consequence of): If eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that leithed exempt Due to (or as a consequence of):									
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	EQUENCE O	F):						
MEDICAL O	PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUS							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF CEATH?		
	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF DEA	ATH YE	S NO	UNCERTAIN	N 🗆		1 🗍 YES 2 🗍 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:		OTHER:						
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ВУ Р	t Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M t V	RK? 'ES 2 ND					
	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, ferm, s	treet, fectory, office		28f. LOCATION (Street City or Town, State,		Rural Route Number,		
OMPLETED		N: To the best of my knowledge, d						ausa(a) and manner on stated		
8	29b. SIGNATURE AND TITLE OF CERTIFIER	· 111		,, spinion, di	29c. LIGENSE NUM			GNED Maath Say, Year)		
E	Xkarles 1	C. Chan	es.	MA	014		► / Z	2/5/94		

· Cleveland Ave

Sess of Person who complete cause of Oeath (ITEM 23 (Typo, Print))

OS R. Chaneh M. 363

3090 Mary July 328 BEGISTRAR'S GRANUE

31994 July Watter Name (1)

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ath. Page 6 may be retained by the hospital or attending physician.	attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit of	
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nours after de	n by	or removal
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The law requires that the death certificate be executed within 24 in	etely 1	e Dept. of Health and Mental Hygiene prior to burial, cremation, or r
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H O	표	e file

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -**CERTIFICATE OF DEATH** 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 199 1:30a m Marion D. Willson December 6 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Forming Sep. 5 HOURS 1 - M 2 -98 YAS. 213-46-9148 1896 Maine 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 7604 Glenbrook Road Bethesda Montgomery 10e. STATE 10b. COUNTY toc. CITY, TOWN OR LOCATION <u>Maryland</u> Montgomery Bethesda 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL tor, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20814 7604 Glenbrook Road U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yee, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried 3 Widowed 4 Divorced BY Specify: White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-t2) College (1-4 or 5+) -4-Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) BE Albert E. Dyer Mary Spear 194. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 36th St. Arlington, Va. 22207 <u>Mary Lea Whitlow</u> 20s. METHOD OF DISPOSITION
1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1359 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Columbia Gardens Cem. Arlington, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY IVES-PEARSON FUNERAL HOMES 2847 Wilson Blvd. Arlington, Va. 23. PART/i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate hock, or heart fallure. List only one cause on each line. intervsi Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Manile resulting in death) CERTIFICATION Sequentisity list conditions. if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 246. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\)—UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one HOSPITAL: 1 YES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO Natural 5 Pending Investigation 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide detarmined 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: the beels of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) end menner ea stated. 29h. SIG ATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, OATE SIGNED (Month, Day Year) nory C61836 12-7-94 2 Perry, M.D. Cause of 1145 27 (pt n Street, N.W. Washington, DC

RESIDENCE AND STREET

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

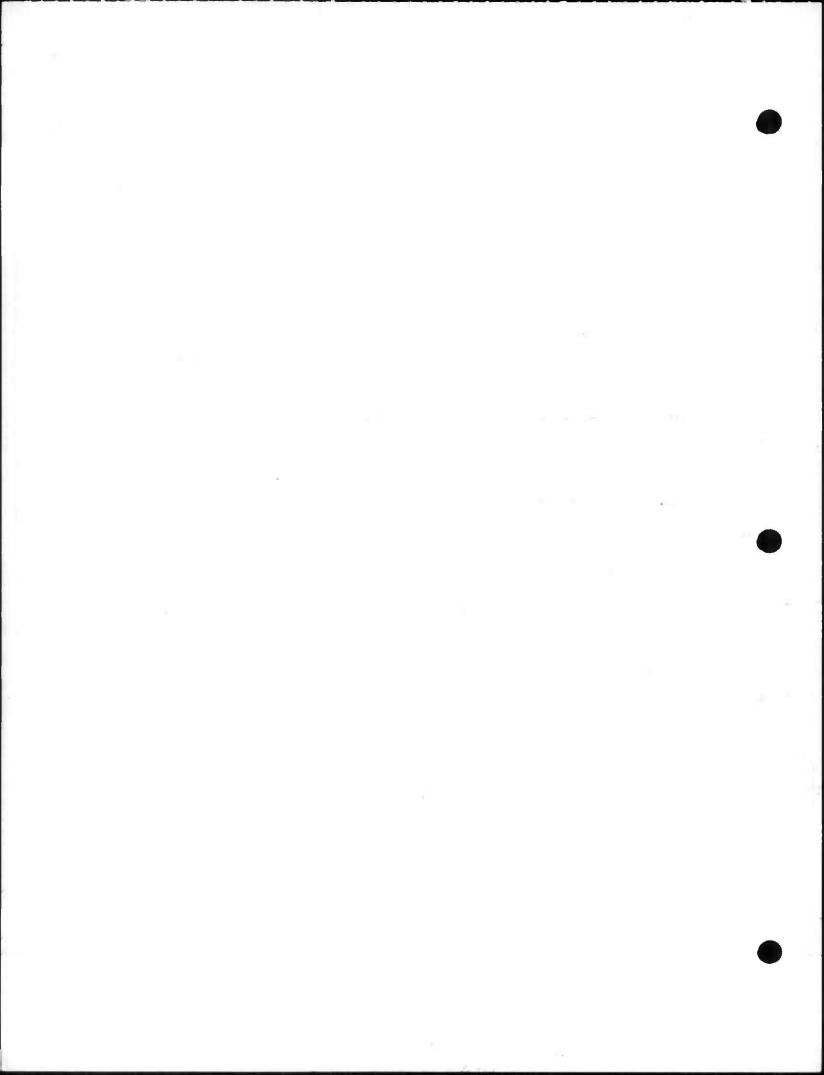
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, L	ast)							OF DEATH			3. TIME OF DEATH	
	May 1-119	1 Truby williams						MONTH DAY YEAR 94 1500					
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR					IF UNDER 24 HRS.	7. DATE	OF BIRTH			PLACE (State or Foreign	
	212-09-4516	7	YRS.	MONTHS DAYS	HOURS MIN.	Man	March 29, 1907 Maryland						
œ	Englanish Manual a v										ATH		
DIRECTOR	RESIDENCE OF DECEDEN	OLIA	ir nospitar			Fred	erick			Fr	eder	rick	
3	190. STATE 10b. COUNTY 10c. CITY, TOWN OR LOC						ATION				T	10d. INSIDE CITY	
ā	Maryland Fr	,	Frederick					LIMITS? 1 YES 2 NO					
AL	Maryland Frederick County Frederick 1 100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHA									23			
E	10546 01d Anna	10546 Old Annapolis Road 21701 U.S.A									SA		
FUNERAL	11. MARITAL STATUS		. WAS DECEDENT EVER II		S. ARMED 13. WAS DECEMBENT OF HIS				PANIC ORIGIN? (Specify Yes or No- 14. RAC			- American Indian.	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced		FORCES? 1 YES	ATES NO)		pecify Cuben, Mexic S 2 NO Speci	Black, White, etc. Specify:					
							71.					White	
E	15. DECEDENT'S (Specify only highest (. KIND OF BU	SINESS/INDU	S/INDUSTRY		
"	Elementary/Secondary (0-12)	C	College (1-4 or 5+)		Do NOT use	,							
COMPLETED			2	C	leri	cal Wor	·k		Pub	lishi	ng		
႘၂	17. FATHER'S NAME (First, Middle, Last	•					18. MOTHER'S NA	AME (First, i	Middle, Maiden	Surname)			
BE	Irving Rub	у						ie J					
[19e. INFORMANT'S NAME (Type/Print)						and Number or Rural				,		
_	Mrs. Jane S. Wa	r'd_		1	0546	-R 014	Annanoli	s Ro	ad Fre	deric	k, N	ID 21.701	
	20e. METHOD OF DISPOSITION 1 N Burlei 2 Cremetion 3 1	Remova	I from State cem	PLACE AP	ND DATE OF	DISPOSITION (leme of	DAT	E 20c. LO	CATION - C	ity or Tow	rn, State	
	4 Donation 5 Other (Specify)		I	ake	View	Mem.	Park 12	2/12/	94 Sy	kesvi	11e,	MD	
	21. SIGNATURE OF FUNERAL SERVIC	E LICENS	SEE	//			NO ADDRESS OF FA		OME (E			05)	
	Duan	K	Haid	4			HT FUNER						
	23. PART I. Enter the diseases,	ог соп	pilcationa that caused	the dea	th. Do no	t enter tha m	ode of dying, suc	ch as care	diac or reep	iratory arre	- / 9) et,	Approximate	
	shock, or heart fails iMMEDIATE CAUSE (Final	ıra, Lisi	t only one cause on a	ach lina.								interval Between Onset and Death	
	disease or condition		R									Onset and Dastii	
- 1	reaulting in death) a. 3-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0									12 11-			
-	,		5600	1-								uc. 10-	
흔	Sequentially list conditions, if any, leading to immediate										7 001		
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury		DUE TO (OR AS A	En	112	m 4	2/0001	5				600	
	that initiated events		DUE TO (OR AS A	CONSEOL	JENCE OF)								
	resulting in death) LAST	d											
បី	PART ii. Other aignificant cond	tions	ontribution to death t		madet - 1	Man and the	200	D					
₹	/			ut not re	-				24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă	- Hypr-c	01/	(6 000 1 2)		/ (7	901	forto.	7	1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?	
Σ												1 YES 2 NO	
Ž I	DID TOBACCO USE CO							N 🗆					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICA EXAMINER?	_	OSPITAL:	26. PLACE		Check only one)						
X	1 TES 2 NO		Separtlent 2 - ER/Outp	atient 3	DOA	I ☐ Nursing Ho	ne 5 🗆 Residence	8 🗆 Othe	r (Specify)				
표	27. MANNER OF DEATH 1 Netural 5 Pending		(Month, Day, Year)		28b, TIME INJU	OF 28c. IN	JURY AT ORK?	28d. DES	CRIBE HOW I	NJURY OCCU	URY OCCURED		
B	1 Netural 5 Pending 2 Accident Investigati	lon					YES 2 NO						
- 4	3 Suicide 8 Could not		28e. PLACE OF INJURY building, atc. (Spec	— At hom ify)	e, ferm, at	eet, factory, off	ce	28f. LOC City	ATION (Street or Town, State)	end Number o	r Rural Ro	oute Number,	
	4 Homicide determine	u											
2		HYSICIA	N: To the best of my knowl	edge, dest	h occurred	at the time, dat	e end place, end due	e to the cau	rse(s) end mai	nner as stated	ı.		
COMPLETED	one) 2 MEDICAL EXAM	MINER: C	In the besis of examination	end/or im	veatigation.	in my opinion,	death occured at the	time, date	end plece, en	d due to the	ceuse(s)	end menner es stated.	
	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										Month, Day, Year)		
											9/94		
2	30. HAME AND ADDRESS OF PERSON	WHO C	OMPLETED CAUSE OF DE	ATH (ITEM	27) (Type, F	Print)					7	16.7	
	3 / _		sca mb	47	01	w	7 62	50	FL	m . d	-, -	1 146	
	31. DATE FILED (Month, Day, Year)	1	32. REGISTRAR'S SIGNA		J/				, ,	. 4	10		
	DEC 13 1994	fort	i Danden Ran	delile									
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

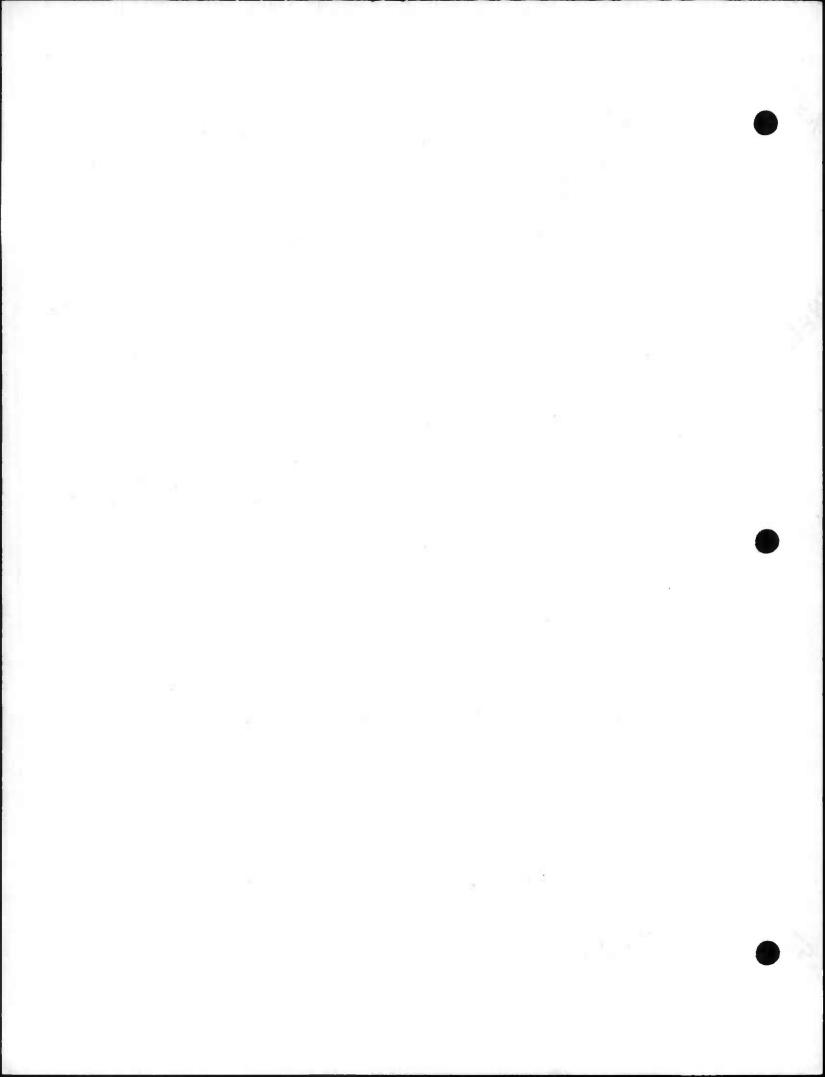
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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

	MEGIOTHAN		- OL	-1111111	CATE	OI.	DEA	111	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest)	Ci	000	1			2. DATE OF DEATH MONTH YEAR			3. TIME OF OEATH			
	4. SOCIAL SECURITY NUMBER	Olmo	. AGE (In yrs. las	n yrs last hirthday) E		YEAR	IF UNDER	24 HRS	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign		
	546-48-6084	1 🗆 M 2 🔽 F	89	YRS.		DAYS	MONTHS MAN (MO		(Month, Day, Year) May 2, 1905	(Month, Day, Year)		Country) Alabama	
	9a. FACILITY NAME (If not institution, give s	ilreet and number)			9b. CITY,	TOWN (OR LOCATE	ON OF DEA	ТН	9c. COL	JNTY OF DE	EATH	
DIRECTOR	Stella Maris Hospice					Towson				Baltimore			
입	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Υ		10c CITY	TY, TOWN OR LOCATION 10d, INS							10d, INSIDE CITY	
DIR	Maryland How		Cooksville							LIMITS?			
A	10e. STREET AND NUMBER				101. ZIP COOE					10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	1175 Hoods Mill		21723				U.S.A.						
5	11. MARITAL STATUS	12. WAS DECEDENT						ORIGIN? (Specify Yea or No. 14, RACE -			- American Indian,		
ВУБ	1 Never Married 2 Merried 3X Widowed 4 Divorced	YES 2 XN OR DATES	Ю	If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2X☐ NO Specify:					Specif	, white, etc. y: White			
ED	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	CEDENT'S	USUAL OCI	CUPATIO	ON at of workin	27	16b. KIND OF BUS	SINESS/IN	DUSTRY		
LET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life.	Do NOT us	e retired.)			ny		Dom		}	
COMPL	17. FATHER'S NAME (First, Middle, Last)		Homemaker				HED'S DAM	E (First, Middle, Malden		Domestic			
BE C	John Dollar	:							beth Davi	,			
0 B	19e. INFORMANT'S NAME (Type/Print)	<u>-</u>							ute Number, City or Town				
F	Mrs. Patricia Ho	oker	11	L75 H	loods	Mi	lL Ro	oad	Cooksvill	e, M	D 217	23	
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem	oval from State	20b. PLACE A cemetery, crei	matory or of	her niecel						City or Ton		
	4 Donation 5 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LIC	CENSEE /	Crest	tlawn				ns 12	/10/94 M	arri	ottsv	ville, MD	
	> Bligge	1 Hais	Ct		H	AIG	HT FU	JNERA	L HOME (P				
	23. PART i. Enter the diseasea, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest.												
	ehock, or heart failure. List only one cause on each line. interval Between Onset and Death												
	disease or condition reaulting in deeth) a. Island actoma												
		DUE TO (C	R AS A CONSEC										
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate out to (OR AS A CONSEQUENCE OF):												
CAT	ceuse. Enter UNDERLYING CAUSE (Disease or injury	c											
	that initiated events	DUE TO (O	R AS A CONSEC	DUENCE OF	7:								
1	resolding in death) Excit	d											
	PART ii. Other aignificant condition	e contributing to d	eeth but not n	ecuiting i	n the und	derlying	ceuse (given in Pa			24b.	WERE AUTOPSY FINDINGS	
EDICAL									PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME									_ / _			1 YES 2 NO	
ä	DID TOBACCO USE	CONTRIBUTE	TO CAUS	SE OF	DEAT	Н Ү	ES [NO	Ø				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF D	EATH (Chec	k only one)				
IXS	1 VES 2 D NO	1 Inpetient 2 E							Other (Specify)				
	1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) M 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED											
ED BY	3 Suicide 6 Could not be	28e. PLACE OF building, et	INJURY At hor	me, ferm, s	treet, factor	ry, offic	•	1	28f. LOCATION (Street a City or Town, State)	and Numbe	or Or Runal A	oute Number,	
	4 Homicide determined								ony or rown, oracoy				
P	29a. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) end menner ea atated.												
COMPLET	one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.												
ш	296. SIGNATURE AND TITLE OF CERTIFIER 29d. OATE SIGNEO (Month, Day, Year)									(Month, Day, Year)			
TO B	Travelle Create Control Dosons								9th 1994				
	1300		OF DEATH (ITEN	1 27) (Type,	Print)	1)r. 6	kend	Iall Fa	uck	mer	y MD.	
1		10 4 U OU 32 REGISTRAR	S SIGNATURE	170		1 (300	son	-md	0)	120)4	
	31. DATE DEC 13 1994		dem-Rand	Leel.									



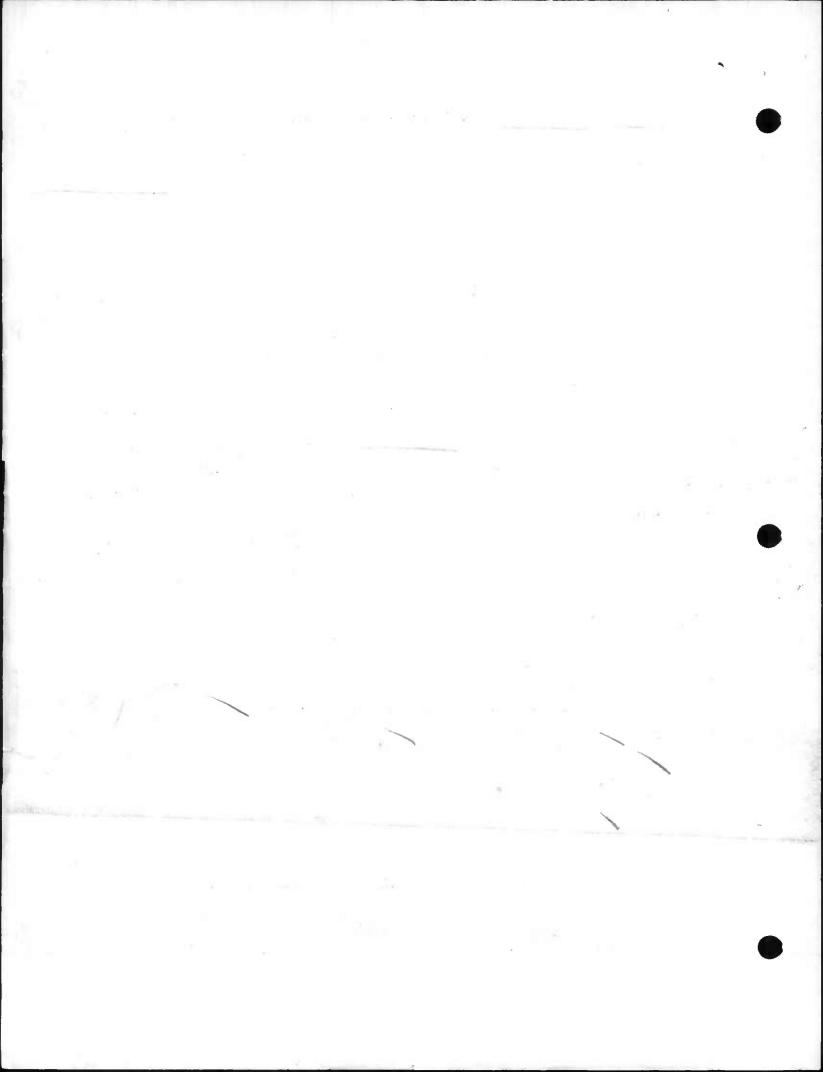
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	uted within	completel	
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isit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and found after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND N	MENTAL HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR		PARTMENT OF HEALTH AND TIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	Paul Arth	nur Zelinka Jr.	2. DATE OF DEATH DAY	YEAR 94 0225 A M
9	213-28-768	7 63	ndey) IF UNDER 1 YEAR IF UNDER 24 HRS. RS. MONTHS DAYS HOURS MIN. 9b. CITY, TOWN OR LOCATION OF	7. DATE OF BIRTH (Month, Day, Year) 9-21-31	6. BIRTHPLACE (State or Foreign Country) MARYLAND
TOR	99. FACILITY NAME (If not institution, give stree HACLOC HOSP RESIDENCE OF DECEDENT	MD 9c. co	UNITY OF DEATH		
DIRECTOR		NE ARUNDEL	C. CITY, TOWN OR LOCATION LINTHICUM		10d. INSIDE CITY LIMITS? 1 YES 2 NO
ERAI	100. STREET AND NUMBER 518 FOUNTAIN DRI	VE	101. ZIP CODE 21090		S.A.
BY FUNERAL		2. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 14 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISP. If yes, specify Cuben, Mexic 1 YES 2 NO Specify		14. RACE — American Indian, Black, White, etc. Specify: WHITE
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co-	mpleted) (Give kir life. Do N	ENT'S USUAL OCCUPATION and of work done during most of working WOT use retired.)	16b. KIND OF BUSINESS/IN	
MPI	12 17. FATNER'S NAME (First, Middle, Last)	N/A MAIN	TENANCE MANAGI		
BE CC	PAUL ARTHUR	ZELINKA, SR.	MILDE	AME (First, Middle, Maiden, Sumane) RED HECI	X
10	190. INFORMANT'S NAME (Type/Print) BETTY LOU ZELIN I		ILING ADDRESS (Street and Number or Rural FOUNTAIN DRIVE	Route Number, City or Town, State, 2	MD. 21090
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	of from State	7 14 Tr 274	rH2/12 ELKRID	- City or Town, State
	21. IRONATURE OF FUNERAL SUPPLICE LIGHT	1/2	22. NAME AND ADDRESS OF A	VENUE, S.W.	FUNERAL HOME
CERTIFICATION	23. PART t. Enter the diseases, or conshock, or haert failure. Lis IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUEN	ary ENGOL Post Loff Cal	1	Interval Between Onset and Death
MEDICAL (PART II. Other significent conditions of		8: = 186	Part I. 24s. WAS AN AUTOPS' PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
	DID TOBACCO USE CO	ONTRIBUTE TO CAUSE		7 2	
PHYSICIAN:	EXAMINER?	IOSPITAL:	26. PLACE OF DEATN (CONTROL OF		
	27. MANNER OF DEATN 1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	D. TIME OF UNDURY AT WORK? M 1 YES 2 NO	26d. DESCRIBE NOW INJURY O	CCURED
тер ву	2 Accident Investigation 3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At home, the building, etc. (Specify)	erm, street, factory, office	261. LOCATION (Street and Numb City or Town, State)	er or Rural Route Number,
COMPLET			ccurred at the time, date and place, and du		
BE	296. SIGNATURE AND TITLE OF CENTIFIER	to Kholy	29c. LICENSE N		TE SIGNED Month, Dal. Year)
T0	30. NAME AND ADDRESS OF PERSON WHO CO		(Type, Print) hieltighway \$5	ioo glen Burn	ie,MD 21061
	12 9 9 DEC 13 1	32 REGISTRAL SISIGNAL TO SE	Raybell		



Jr.,

32. REGISTRARIS SIGNATURE RAN

M.D.,

Smith,

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Cours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Dr.

George I.

31. DATE FILED (Month, Day, Year)
DEC 0 2 1994

	Amenaea #1, 1	ر المراداداد	KCD	. 00.			7	4	00000
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		RTMENT OF I		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	th Hargett		ALBAUGH		2. DATE OF DEATH MONTH NO Vember 2	29, 19	94	TIME OF DEATH
	214-42-0951 9. FACILITY NAME (If not institution, give	5. SEX 1 M 2 F	YRS.	MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN,	Sept. 19,	1903	Country)	Maryland
TOR	Frederick Memor		9b. CITY, TOWN	Frede		9c. COUNT	Y OF DEATH	rederick	
DIRECTOR	Maryland 106. COUNT	Frederick	10c. CIT	Y, TOWN OR LOCA	Frede	rick			LINSIDE CITY LIMITS? YES 2 NO
FUNERAL	1411 Pinewood	Drive		10	2170	1	10g. CITIZE	N OF WHAT	COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 TYES 2 TIF YES, GIVE WAR OR DATES	RMED (NO	If yes, sp		NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.) y:	n or No — 14	Black, Wh Specify:	American Indian, lite, etc. White
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)	completed) (iii	Give kind of the Do NOT u		ON sst of working	16b, KIND OF BU	siness/indus		
BE COI	17. FATHER'S NAME (First, Middle, Last) William H. Thom				E	ME (First, Middle, Maiden ffie S. Ha	rgett		
5	19. INFORMANT'S NAME (Type/Print) William S. Rhoad		8 K1	ine Blvd	nd Number or Rural Frede	Route Number, City or Tow	n, State, Zip Co	21701	
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem 4 Donelion 5 Other (Specify)			of disposition (Ne		DATE 20c. LO	cation – cit		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	10002	22. NAME A	eeney an		Funera	al Hor	ne
	23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition	List only one cause on sech lin	10.	not entar tha mo	da of dying, auc	h as cardiac or resp	retory arres	ξ,	Approximate interval Between Onset and Death
z	resulting in death)	a. (ES () (A TO DUE TO (OR AS A CONSE DUE TO (OR AS A CONSE	EOUENCE O	FAILUI	(PLOO	ASLE			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Carcing A. Due to (or as a conse	4 0	of The	. tes	un (PK	LOND	LE)	
PHYSICIAN: MEDICAL C	PART II. Other algorificant condition	na contributing to death but not	resulting	In the underlyin	g cause given in	Part I. 24e. WAS AN PERFOR	IMED?	AMAI COM OF E	RE AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?
N.	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEA	ATH YE	S NO	UNCERTAI	N D		'	YES 2 NO
YSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO	26. PLA HOSPITAL: 1 Impatient 2 ER/Outpatient		OTHER:	e 5 🗆 Realdence	6 Other (Specify)			
ву РН	27. MANNER OF DEATH 1	28a. DATE OF INJURY (Month, Day, Year)		M 1	PRK? YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCUP	RED	
0	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At h building, atc. (Specify)	ome, farm,	street, factory, offic	•	281. LOCATION (Street and City or Town, State)	and Number or	Rural Route	Number,
COMPLETE		ICIAN: To the best of my knowledge, d							manner sa stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	1. Compl	9	10	29c. LICENSE NU			IGNED (Mon	th, Day, Year)
	1 30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF DEATH (ITI	EM P7) /Type	Print)					,

300 West Ninth St., Frederick, Md. 21701

The second secon

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TE OF MARYLAN		MENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
- 8		*	orahams			Nov. 28		4:00 P M
3	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In)		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	219-03-4970 1 W			9h CITY TOWN C	PR LOCATION OF DE	March 27	1900 9c. COUNTY	New York
E E	26301 Howard Char			_	ascus			ntgomery
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY		40° CITY	TOWN OR LOCAT	TON!			
OIR	Maryland Montgo	merry	IOC. CITY,	-	ascus			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
1 N	10e. STREET AND NUMBER				. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	26301 Howard Char				20872	2	Unite	ed States
5	11. MARITAL STATUS 1 Never Merried 2 Married FO	S DECEDENT EVER IN U	.S. ARMED 2 NO	If yes, sp	ecify Cuben, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No — 14.	RACE — American Indian, Black, White, etc.
B	3 Wildowed 4 Divorced	W.W.1	S	1 TYES	2 NO Specify	y:		Specify: White
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete	16	8s. DECEDENT'S U (Give kind of wo	rk done durina ma	ON st of working	16b. KIND OF BU	SINESS/INDUST	
Ä	Elementery/Secondary (0-12) College	ge (1-4 or 5+)	life. Do NOT use			72 - 2	77 - 4 - 4 -	
COMPL	17. FATHER'S NAME (First, Middle, Lest)		Deve	loper	16. MOTHER'S NA	ME (First, Middle, Malden	Estate	
BE C	Abe Abrahams					ther Forman		
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ODRESS (Street a		Route Number, City or Tow		de)
١٩	Barbara Watkins					Larksburg,	Md. 20	871
	20s. METHOD OF DISPOSITION 1 Burlal 20 Cremetion 3 Removal from	m State cemete	ACE AND DATE OF	er plece)	12/2	/94	CATION — City	3 482.13 =
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Mor	rtgomery		orium, In		thesda	. Md.
1 1	+Ol. Pan	1 -	4	Olin	L. Moles	sworth, P. I		
Н	23. PART I. Enter the diseases, or complete	ations that caused the	he death. Do no	t enter the mo	de of dying, auc	Rd., Damaso	cus, Mo	Approximata
	shock, or heart failure. List do	ly one cause on sach	h Ilna.		,g,		and y direct	Interval Batween Onsat and Daath
	The state of the s	DUE TO (OR AS A CO	mvoc	endial	intar	oction		<30min
NO.	Sequentially list conditions, If any, leading to immediate	TO LESCIE	ONSEQUENCE OF)	acuios	asca 1ar	disease		3/000
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO JOR AS A CO		(A)				>/910
CERTIFICATION	that initisted events resulting in death) LAST	DUE TO OR AS A CO	ONSEQUENCE OF)	-(.0				10.00
1 15	d	nild ren	20/175	w Tru	eny			1985
F	PART II. Other significant conditions control	ibuting to death but	not resulting in		cause givan in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC	Empty Sella by	PAT SUAN 1	ormal/a	ill De	pression	1 YES 2	1	COMPLETION OF CAUSE OF DEATH?
Σ	chrous yacis,	OAN 197.	3 (1990)	the won	ty)		' '	1 _ YES 2 _ NO
AN	25. WAS CASE REFERRED TO MEDICAL	Symptemet	- 67 4p	ser 6/1	SCA &S ACE OF DEATH (Ch	eck only anal		
Sic		PITAL: patient 2 ER/Outpatie		OTHER:		6 Other (Specify)		
PHYSICIAN:		8e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 26c. INJ		28d. DESCRIBE HOW I	NJURY OCCUR	ED
B	1 Natural 5 Pending 2 Accident Investigation	1955 12 12		M t 🗆 Y	res 2 No			
0	3 Suicide 6 Could not be 4 Homicide datermined	Be. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, str	reet, factory, office		28f. LOCATION (Street in City or Town, State)	and Number or F	Rural Route Number,
COMPLETED	29s. CERTIFIER CERTIFYING PHYSICIAN: TO	the heat of my knowled	an death arms of					
JA P	(Check only one) 2 MEDICAL EXAMINER: On the							use(s) and manner as stated.
ECC	296. SIGNATURE AND TITLE OF CERTIFIER	/			29c. LICENSE NUN			GNED (Month, Day, War)
10 B	Joanne & XC	ma			D346	082		v. 29, 1994
F	30. NAME AND ADDRESS OF PERSON WHO COMP	~			unak O±	Danie		
	Joanne L. Kinney,	_	1	New Ch	uren St.	, Damascus	, Md.	20012
	31. DATE FILED (Month, Day, Year) 1994	2. REGISTRATES SIGNATURE	in Vandally					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF I	EALTH AND	MENTAL HYG		•	000.0
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	N		3. TIME OF OEATH
1	Julia Whit	e Anders	son			Dec (03 199	YEAR Q4	7P M
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. lest birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		6. BIRTI	PLACE (State or Foreign
	264-36-0921	□ M 2X□ F 82	YRS.	ONTHS DAYS	HOURS MIN,	Oct 12		Count	(Y)
	9e. FACILITY NAME (If not institution, give street		9	b. CITY, TOWN	OR LOCATION OF DE			NTY OF D	st Virginia
E E	Anne Arundel Medic	cal Center			apolis		1		rundel
5	RESIDENCE OF DECEDENT	out outton		7 (1111	арона				i dilaci
DIRECTOR	10e. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
	MD Anne A	rundel		Annapo	lis				1 YES 2 NO
₩.	10e. STREET AND NUMBER			10	. ZIP CODE		11.7		WHAT COUNTRY?
FUNERAL	433 Dewey Drive				21401		Ur	ited	States
三		WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	CENDENT OF NISPAN ecify Cuben, Mexica	IIC ORIGIN? (Specif	Yes or No-	14. RACI	E — American Indien, k, While, etc.
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES		2 NO Specify		,	Spec	Mar.
	15. DECEDENT'S EDUCATION	Su .							" White
E	(Specify only highest grade comp	pleted)	(Give kind of work life. Do NOT use n	k done during mo	ost of working	16b. KIND OF	BUSINESS/IN	DUSTRY	
F	Elementary/Secondary (0-12) Co	6 (1-4 or 5+)		,			E.J.		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)	0	Teach	er				ıcatio	on
						ME (First, Middle, Ma			
BE	Michael White 190. INFORMANT'S NAME (Type/Print)		T 10h MAN INC AT	DDECC (Character	Anr	na Siduru	Κ		
5	Patrick S. Anderson								,
	200 METNOD OF DISPOSITION		PLACE AND DATE OF		er Ct. Li		LOCATION -		
	1 Description 2 Cremetion 3 Removal	from State cem	etery cremetory or other fillcrest C	place)	10/6	/OA	LOCATION —	City or it	Accuted
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	EE //	micrest C	22. NAME A	Y IZ/O	CUTY John A	Annapo	IIS, I	uneral Home
		1 1							
	MAUM XI	MILIA			uke of G				olis, MD
	23. PART 1. Enter the diseeses, pr comp shock, pr heert fellure. List	olicetions that caused only one cause on e	the deeth. Do not sch line.	enter the mo	de of dying, suc	h ea cerdiec or n	epiratory ar	reet,	Approximate Interval Between
	IMMEDIATE CAUSE (Finsi	/ Ats	1-	0		1 /		_	Onset suff Death
	disease or condition resulting in death) e	Hlucion	elevatie a	ande	ovasent	an dise	ase	2	months
		DUE TO (OR AS A	CONSEQUENCE OF):						
NO N	Sequentially liet conditions, b.	DUE TO COR AS A	CONSEQUENCE OF:						
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE TO (OR AS A	CONSEQUENCE OF):						
윤	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF:						
E	resulting in deeth) LAST								Ì
	d								
AL	PART ii. Other eignificent conditions co	intributing to deeth be	ut not recuiting in t	the underlyin	g ceuse given in	Pert i. 24a. WAS	AN AUTOPSY	24b	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
음	Organic bra	in Synde	me with	inan	ition		S 2 XNO		COMPLETION OF CAUSE OF DEATH?
¥		0							1 YES 2 NO
ż	DID TOBACCO USE CONTRIBU	JTE TO CAUSE O	F DEATH YES	□ NO D	UNCERTAIN	4 D			
ĕ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATN						
PHYSICIAN: MEDIC		SPITAL:		THER: Nursing North	e 5 🗆 Residence	6 Other (Specify)			
H	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O		URY AT	26d. DESCRIBE NO	W INJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
	3 Suicide 6 Could not be	26e. PLACE OF INJURY building, etc. (Speci	— At home, farm, atre-	et, fectory, offic	•	281. LOCATION (Sti City or Town, S	eet end Numbe	r or Rural F	loute Number,
						ony or lown, o	1010)		
1	4 Nomicide determined							_	
PLETE	4 Nomicide determined	: To the beat of my knowl	edge, death occurred a	it the time, date	end place, end due	to the cause(e) end	manner ee sta	ted.	
OMPLETE	4 Nomicide determined 29e. CERTIFIER (Check only) end menner ee stated.
COMPLETED	4 Nomicide determined 29e. CERTIFIER (Check only				eath occured at the	time, date end place	, end due to ti	ne ceuse(e	
BE	4 Nomicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Or	the beele of examination				time, date end place	e, and due to the	e SIGNED	(Month, Day, Year)
	4 Nomicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Or	the beele of examination	end/or Investigation, I	n my opinion, d	eath occured at the 29c. LICENSE NUM	time, date end place	e, and due to the	e SIGNED	
BE	4 Nomicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On Determined 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WNO CO	the beele of examination	end/or Investigation, I	n my opinion, d	29c. LICENSE NUN D05928	time, date end place	29d. DAT	E SIGNED	(Month, Dey. Year) 1ber 5, 1994
BE	4 Nomicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 29b. SIGNATURE AND TITLE OF CERTIFIER	the beele of examination	ATN (ITEM 27) (Type, Pri	n my opinion, d	29c. LICENSE NUN D05928	time, date end place	29d. DAT	E SIGNED	(Month, Dey. Year) 1ber 5, 1994
BE	4 Nomicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Or 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WNO CO Charles W. Kinzer, M.	MPLETED CAUSE OF DEA	ATN (ITEM 27) (Type, Pri	n my opinion, d	29c. LICENSE NUN D05928	time, date end place	29d. DAT	E SIGNED	(Month, Dey. Year) 1ber 5, 1994

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	r		REG. NO.	
			1. DECEDENT'S NAME (First, Middle, Last) CAROLINE W. ATTEN 2. DATE OF DEATH MONTH 11-20-94 YEAR 3. TIME OF DEATH 11-20-94 TAM	м
			4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthdpy) # UNDER 1 YEAR # UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 GF YRS. MONTHS DAYS HOURS MIN.	
	should		9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	_
	1, 2, 3	ECTOR	230 Charrel Oak of Annapolis A.A.	
	Pages	뜸	10e. STATE 10b. COUNTY A.A. 10c. CITY, TOWN OR LOCATION AUNAPOULS 10d. INSIDE CITY LIMITS? 1 □ YES 2 SLINO	
	ansit permit.	FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? USA	
	s the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Merried 2 Merried 12. WAS DECEGENT EVER IN U.S. ARMEO FORCES? 1 YES 2 Merried 1 YES 2	
	use as	冒	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY	
S P	pd for	APLET	Elementary/Secondary (0-12) College (1-4 or 5+) As mandaken (1-5 me)	
⋖ ७	d be detached f at once.	E COMP	17. FATHER'S NAME (First, Middle, Last) Walter Wallace 16. MOTHER'S NAME (First, Middle Meiden Surname) May Byrns	
2 = 1	notified	TO B	190_INFORMANT'S NAME (Type/Print) 190_ MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Van Burenser, Annapolis, Maj 1403	<u> </u>
0 5	ector, page		20e. METHOD OF DISPOSITION 1 Gurial 2 Greenetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, greenatory of Other place) 4 Donation 5 Other (Specify)	
Page	e Tuneral Olector. L. examiner mus		21. SIGNATURE OF UNEFIAL SETVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	_
	e = es		* Kobil Sawanco Severne Park FH.	
Sin .	etery med in by the emation, or removal. It, the medical or		23. PART I. Enter the diseases, or complications that caused the seath. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feiture. List only one cause on a line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a	
executed w	burial, crem	z	DUE TO (OR AS A CONSEQUENCE OF):	
OB.	prior to buri	CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	
P.O. B	Hygiene or other	CERTIFICATION	CAUSE (Disease or Injury that initiated events	
Geat Geat	Mental Injury, C	- 11	PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDING	
T # .	3	EDICAL	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE	5
- 5	of Heal	Σ	1 YES 2 NO	
	Dept.	AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	╝
VITAL AN: The tav	the State [SICI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 % Residence 5 Other (Specify)	3
PHYSICI		Y PHYSICIAN:	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28e. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED M 1 YES 2 NO	
ATTENDING PHYSICIAN: The	ther on	TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined Could not be determined Phomicide Investigation 25e. PLACE OF INJURY — At home, term, street, factory, office City or Town, State) 25e. PLACE OF INJURY — At home, term, street, factory, office City or Town, State)	7
5 8	元 12 元	COMPLET	29e. CERTIFIER (Check only one) 29 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner se stated.	
	- >	шШ	2 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITUE OF COMPARY 1.00 And The Company of the Company	\dashv
5	be filed	TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
			A. PLECIS, MD 1509 RITCHIE HWY ARNOLD MD 21012	
			31. DATE FILED (Month Dec year) 08 1994 Julia Danielar Roydall	
	-			

100 --

578-10-1832 DAYS 1 X M 2 - F YRS. 77 Page 6 may be retained by the hospital or attending physician. all director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9h. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Holy Cross Hospital Silver Spring ton. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring FUNERAL toe. STREET AND NUMBER 1102 Devere Drive 20903 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED BALTIMORE, MARYLAND 21215-0020 t Never Married 2 XMarried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES ВУ 3 Widowed 4 Divorced WWII 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Accountant 17. FATHER'S NAME (First, Middle, Last) notified at Israel Ansell BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or 2 Lillian Ansell (Wife) pe 20a. METNOD OF DISPOSITION

TX Burial 2 Cremailon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must the funeral director, Donation 5 Other (Specify) Mt. Lebanon 21 SIGNATURE OF FUNERAL SERVICE LICENSEE examiner ours after death. ranh medical 23. PART I. Enter the disease, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdisc or reepiratory errest, in by shock, or heart fellura. List only one cause on each line. 0 ysician and completely filled prior to burial, cremation, or IMMEDIATE CALISE (Fine) the diseese or condition___ event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, the death certificate be executed with traumatic CERTIFICATION Sequentielly list conditions. If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other thet initiated avents reaulting in death) LAST 0 the atter PART ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL and t geman 1040 any Signed t Shows been to of b has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? certificate h HOSPITAL: Inpatiant 2 - ER/Outpatient 3 - DOA 10 the 27. MANNER OF DEATH 28b. TIME OF 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, this (1 Netural 2 Acciden 5 Pending BY After t Accident Investigation DIRECTOR: Af hours after de Item 28 is r 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) e Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as steted. FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II Suu q, BE Bruce A. SINCE, 41.0, 2101 Medical Park Dr., 5ther String, and. 20902

1 - FOR STATE REGISTRAR

t. DECEDENT'S NAME (First, Middle, Last)

6. AGE (In vrs. last birthday)

IF UNDER 1 YEAR

HOURS

10f. ZIP CODE

Sidney Ansell

4. SOCIAL SECURITY NUMBER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH MONTH November 1994 2:10 P 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. May 19, 1917 North Carolina Montgomery tod. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES X NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Public Accountant 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rehecca Salzherg

City or Yown, State, Zip Code) 1102 Devere Drive Silver Spring, Md. 20903 20c. LOCATION — City or Town, State DATE 11-28 Adelphi, Maryland 22. NAME AND ADDRESS OF FACILITY Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, Md. 20852 Interval Between Onset and Death Paray topenia and Sepsis secondary to characterists hours

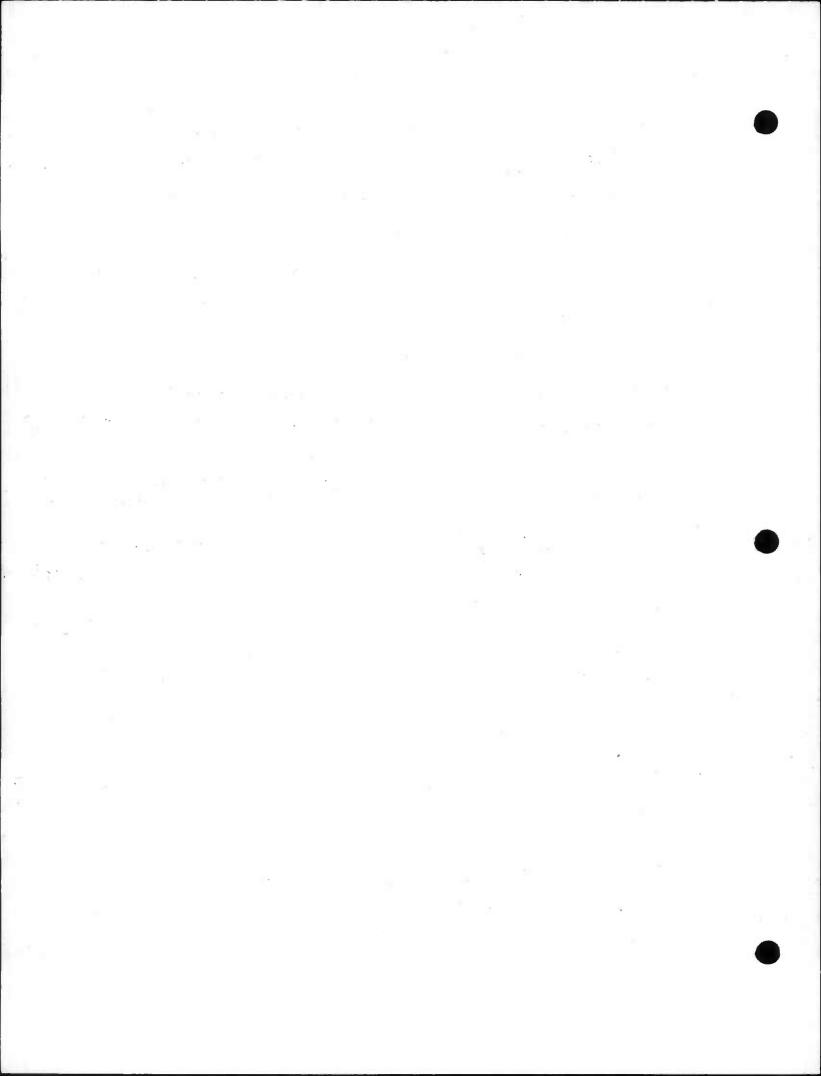
Due to (or as a consequence of): and radiation

Metastatatic can up

Bladder cancer

Syears 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 YES 2 NO 28. PLACE OF DEATN (Check only one) 4 Nursing Home 5 Realdence 6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year)

1/1-26 - 94



once.

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notified

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must

the medical examiner

event,

traumatic

injury, or other

shows any

Item 23

marked,

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28

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BE

2

(Check only one)

0 DEC

permit. Pages 1, 2, 3 should

26s. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

1 CERPIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. MEDICAL EXAMINER: On the beale of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 296. SIGNATURE AND TITLE OF DERTIFIED.

Jus

30. NAME AND ACORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ber 31. DATE FILED (Month, Day, Year) 32. REGISTRAN'S SIGNATURE Jandall 1994

29c. LICENSE NUMBER

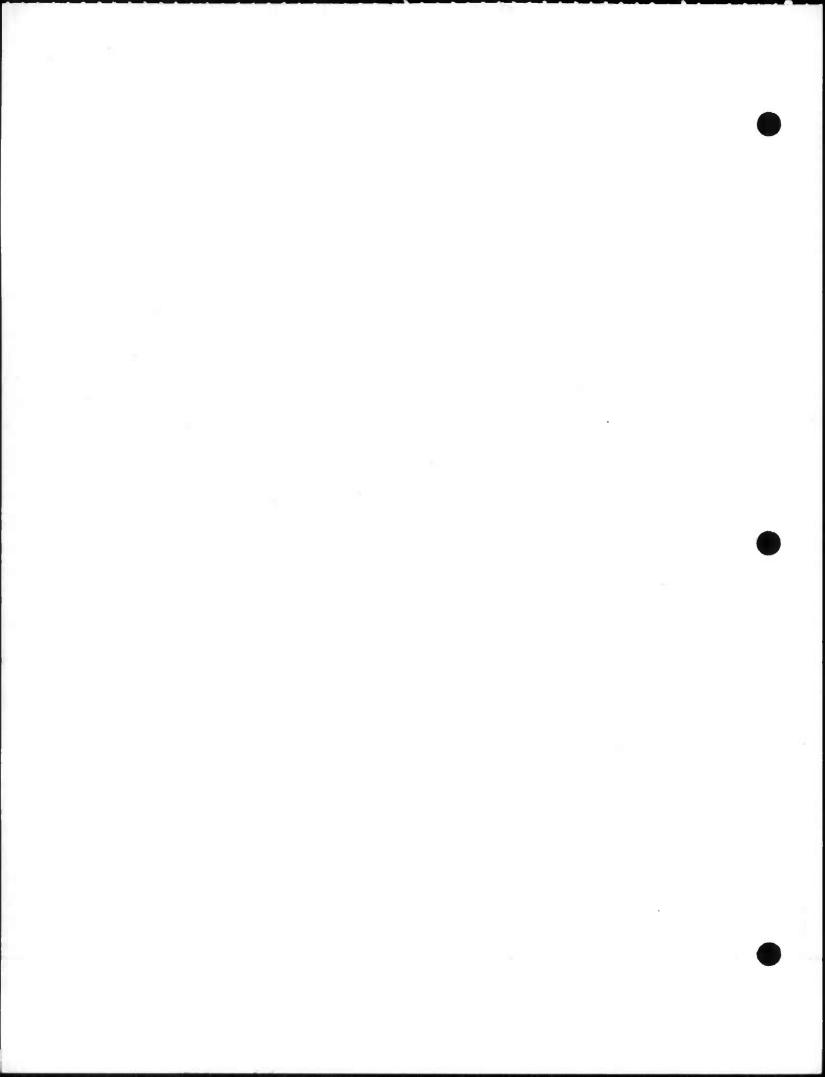
2

29d. DATE SIGNED (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

- 1	REGISTRAR				CATE	DEATH	RE	G. NO.		
- 1	1. DECEDENT'S NAME (First, Middle, La	st)					2. DATE OF DI	EATH		3. TIME OF DEATH
1	Ernest Burton	Abrahamson					Novemb	ar 2/	1 Q Q /	6:35 PM M
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. las	t hirtholms)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BI			HPLACE (State or Foreign
	459-26-7155	1 X M 2 F			MONTHS DAY		(Month, Day, Sept.	Year)	Count	ny) nio
		*-	72	THO.			Sept.	30, 19	124 01	110
	9a. FACILITY NAME (If not institution, gi	re street and number)			9b. CITY, TOW	N OR LOCATION OF DE	ATN	9c.	COUNTY OF I	DEATH
OH	208 Hillsboro	Drive			Silv	er Spring			Montgo	omery
5	RESIDENCE OF DECEDENT									
믬	10e. STATE 10b. COU				TOWN OR LO					10d. INSIDE CITY LIMITS?
ō	MD Mo	ntgomery		Si	lver S	pring				XX LIMITS?
AL	10e. STREET AND NUMBER					10f, ZIP CODE		10g	CITIZEN OF	WHAT COUNTRY?
E	208 Hillsboro	Drive				20902		Ţ	nited	States
BY FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT F FORCES? 1	EVER IN U.S. AR	MED	13. WAS I	ECENDENT OF HISPAN	IIC ORIGIN? (Sp	ecify Yea or No	14. RAC	E — American Indian
E	1 Never Married 2 Narried	FORCES? 1 X		10	If yes,	specify Cuban, Maxica	n, Puerto Ricen,	etc.)	Blec	E — American Indian, ck, White, etc.
BY	3 Wildowed 4 Divorced	ir rzs, dive wan	OR DATES		''''	ES 2 NO Specify	/ :		Spec	White
0	15. DECEDENT'S E	DUCATION	18a, DE	CEDENT'S I	JSUAL OCCUP	ATION	185 KIND	OF BUSINES	e/INDITETOV	
Ë l	(Specify only highest gi		(Gi	ive kind of w Do NOT use	ork done during retired.)	most of working	1000 1000	0, 000,,,,	0,1110001711	
7	Elementery/Secondary (0-12)	College (1-4 or 5+)			100	Engineer		II S	Govern	nmant
COMPLETED		•		11000	rear					ment
ပ္ပ	17. FATHER'S NAME (First, Middle, Last) Ernest Abraham					16. MOTHER'S NA		Maiden Surna	me)	
BE		5011					e Falls			
은 [19a. INFORMANT'S NAME (Type/Print)					et and Number or Rural I				
-	Carol Foley			16104	Kent	Road, Laui	cel, MD	20707		
	20a METNOD OF DISPOSITION 1 Durial 2 Cremation 3 R				F DISPOSITION	(Name of	DATE	20c. LOCATIO	N — City or To	own, Stata
	4 Donation 5 Other (Specify)	amoval from State	Gate	of H	er place) eaven	11/28/	/94	Silve	r Spri	ing, MD
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE /	1 0000	VI II		AND ADDRESS OF FA		DIIVC	L OPL	LIIG, IID
	D 50 16.	76				s-Rinaldi				MD
	Tioma	V Duck			1180	O New Hamp	shire	Avenue	Silve	er Spring I
	23. PART I. Enter the diseases, abock, or heart fallu	or complications that c re. List only one cause	aused the de	ath. Do no	ot enter the	mode of dying, such	n aa cardiac o	r reapirator	y arreat,	Approximate
	IMMEDIATE CAUSE (Final	c. List only one cause	On each line	•						Interval Between Onset and Death
	disease or condition	metas	chatic	·	rosto t	e cance	3 1			1100.05
	resulting in death)	a. metas DUE TO (OI	R AS A CONSEC	DUENCE OF	:	Canco	71			gears
- 1		arter	insolo	ratio	laca	rt disea	CP			1460-50
ó	Sequentially list conditions,	b. DUE TO (Of	R AS A CONSEC	DUENCE OF	, pr	11368	10			years
AT	If any, leading to immediate cause. Enter UNDERLYING	,								
유	CAUSE (Disease or Injury	C. DUE TO (OI	R AS A CONSEC	DIENCE OF						
ĒΙ	that initiated events reaulting in death) LAST	-02 10 (01	THO H CONSEC	JOENOL OI	•					i I
剪】		_ d								
L CERTIFICATION	PART II. Other aignificant condit	dd.	eath but not r	eaulting Ir	the underly	ing cause given in	Part I. 24a.	WAS AN AUTO	PSY 24h	D. WERE AUTOPSY FINDINGS
	PART II. Other algnificant condit					Ing cause given in		PERFORMED?		AVAILABLE PRIOR TO
	_ anemic	a of chron	ic di	sease						
EDICAL	anemic paroxy	smal atrio	ic di	sease bril	lation			PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	anemic paroxy DID TOBACCO USE CON	smal atria	ie di al fi SE OF DEA	sease bril	lation D NO	UNCERTAIN	_ 10	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
EDICAL	anemic paroxy	smal atrio	ie di al fi SE OF DEA	Sease Bril TH YES	lation NO (Check only o	UNCERTAIN	_ 10	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
EDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	smal atria	SE OF DEA	Sease Bril TH YES	lation NO I (Check only o	UNCERTAIN	10	YES 2 A		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
EDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	NTRIBUTE TO CAUS	SE OF DEA 26. PLAC R/Outpatient 3 JURY	SEASE Bril TH YES E OF DEATH	Aton NO (Check only o OTHER: 4 Nursing H	UNCERTAIN ne) ome 5 Pheeldence	10	PERFORMED? YES 2 7 M	6	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	NTRIBUTE TO CAUS HOSPITAL: 1 Inpatient 2 El 280. DATE OF IN. (Month, Day.	SE OF DEA 26. PLAC R/Outpatient 3 JURY	Sease bril TH YES	AHON AHON Check only o OTHER: 4 Nursing H OF 28c,	UNCERTAIN TO OTHER 5 PAREIDENCE	1 1 8 Other (Spec	PERFORMED? YES 2 7 M	6	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigated Investigated	HOSPITAL: 1 Inpattent 2 El 28e. DATE OF IN 28e. PLACE OF IN	SE OF DEA 26. PLAC R/Outpatient 3 JURY Yee/)	SEASE Bril TH YES E OF DEATH	A HON OTHER: 4 Nursing H OF RY M 1 [UNCERTAIN TO OME 5 PResidence INJURY AT WORK? YES 2 NO	8 Other (Specaled Describe	PERFORMED? YES 2 (2)-A	occured.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: Tribute to CAUSTIN	SE OF DEA 26. PLAC R/Outpatient 3 JURY Yee/)	SEASE Bril TH YES E OF DEATH	A HON OTHER: 4 Nursing H OF RY M 1 [UNCERTAIN TO OME 5 PResidence INJURY AT WORK? YES 2 NO	1 1 8 Other (Spec	YES 2 DAN	occured.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 1 nevestigated 2 Accident Investigated 3 Suicide 8 Could not detarmined	HOSPITAL: Impetiant 2 El 280. DATE OF IN Month, Day, 280. PLACE OF III building, atc	SE OF DEA 26. PLAC R/Outpatlent 3 JURY JURY NJURY — At hor.: (Specify)	TH YES DOA 20b. TIME INJU	A HONO (Check only o OTHER: (I) Nursing H OF RY M 1 [Treet, factory, o	UNCERTAIN TO OTHE 5 PRESIDENCE INJURY AT WORK? YES 2 NO	8 Other (Spee 28d, DESCRIBE 281, LOCATION City or Tow	PERFORMED? VES 2 DA City) E NOW INJURY (Street and Num, State)	OCCURED	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not detarmined 29e. CERTIFIER (Check only) 1 CERTIFYING PM	TRIBUTE TO CAUS HOSPITAL: 1 Inpettant 2 El 280. DATE OF IN (Month, Day, 280. PLACE OF II building, atc	SE OF DEA 26. PLAC R/Outpatlent 3 JURY Vee/ NJURY — At hor. (Specify)	TH YES E OF DEATH	A HONO Check only o OTHER: 4 Nursing H OF RY M 1 reet, factory, o	UNCERTAIN TO DO THE STATE OF TH	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s)	PERFORMED? YES 2 D M City) E NOW INJURY (Street and No. n., State)	OCCURED	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not detarmined 29e. CERTIFIER (Check only) 1 CERTIFYING PM	HOSPITAL: Impetiant 2 El 280. DATE OF IN Month, Day, 280. PLACE OF III building, atc	SE OF DEA 26. PLAC R/Outpatlent 3 JURY Vee/ NJURY — At hor. (Specify)	TH YES E OF DEATH	A HONO Check only o OTHER: 4 Nursing H OF RY M 1 reet, factory, o	UNCERTAIN TO DO THE STATE OF TH	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s)	PERFORMED? YES 2 D M City) E NOW INJURY (Street and No. n., State)	OCCURED	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
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BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigate 3 Sufcide 8 Could not detarmined 29. CERTIFIER (Check only one) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIFIER	HOSPITAL: HOSPITAL: 1 Inpatiant 2 El 28e. DATE OF IN. (Month, Day. 28a. PLACE OF III building, atc	SE OF DEA 26. PLAC R/Outpatlent 3 JURY Vee/ NJURY — At hor. (Specify)	TH YES E OF DEATH	A HONO Check only o OTHER: 4 Nursing H OF RY M 1 reet, factory, o	UNCERTAIN THE DESCRIPTION OF THE PROPERTY OF T	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s) iffime, data and p	PERFORMED? VES 2 D A City) E NOW INJURY (Street and Num, State) and manner as olsce, and dua	o OCCURED where or Rural I stated. to the cause(a	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
COMPLETED BY PHYSICIAN: MEDICAL	A NEWLO DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 8 Could not detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIFIER May Hay	HOSPITAL: 1 Inpetiant 2 Ei 280. DATE OF IN (Month, Day, 10 280. PLACE OF II building, atc YSICIAN: To the beat of my INER: On the beat of exame EIER LYN MD	SE OF DEA 26. PLAC R/Outpatient 3 JURY JURY NJURY — At hor. (Specify) / knowledge, de- ninetion and/or i	TH YES E OF DEATH 28b. TIME INJU me, ferm, st sth occurred investigation	A HONO (Check only o OTHER: 4 Nursing H OF RY M 1 reet, factory, o	UNCERTAIN THE DESCRIPTION OF THE PROPERTY OF T	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s)	PERFORMED? VES 2 D A City) E NOW INJURY (Street and Num, State) and manner as olsce, and dua	o OCCURED where or Rural I stated. to the cause(a	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	A NEWLO DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 3 Suicide 8 Could not detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIFIER May Hay	HOSPITAL: HOSPITAL: Inpettent 2 El Sea. DATE OF IN. (Month, Day. Obe 28a. PLACE OF III. building, atc. YSICIAN: To the best of my INER: On the best of exemple ER WNO COMPLETED CAUSE (INC.)	SE OF DEA 26. PLAC R/Outpatient 3 JURY JURY NJURY — At hor. (Specify) / knowledge, de- ninetion and/or i	TH YES E OF DEATH 28b. TIME INJU me, ferm, st sth occurred investigation	OF 28c. RY M 1 [reet, factory, o	UNCERTAIN THE DESCRIPTION OF THE PROPERTY OF T	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s): 1flme, data and p	City) E NOW INJURY (Street and Num, State) and manner as place, and dua	occured more or Rural I stated. to the cause(c	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and manner as stated. 2 (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 No 27. MANNER OF DEATH 2 Accident Investigation 3 Suicide 8 Could not determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIFIED AND ADDRESS OF PERSON Martha Kern	TRIBUTE TO CAUSE HOSPITAL: 1 Inpatiant 2 Et 28e. DATE OF IN. (Month, Day. 28a. PLACE OF II building, atc VICIAN: To the beat of my INER: On the beat of example the complete the	SE OF DEA 26. PLAC 26. PLAC R/Outpatient 3 JURY Year) NJURY — At hor.: (Specify) A knowledge, de inination and/or I	TH YES E OF DEATH 28b. TIME INJU me, ferm, st sth occurred investigation	A HONO (Check only o OTHER: 4 Nursing H OF RY M 1 reet, factory, o	UNCERTAIN THE DESCRIPTION OF THE PROPERTY OF T	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s): 1flme, data and p	PERFORMED? VES 2 D A City) E NOW INJURY (Street and Num, State) and manner as olsce, and dua	occured more or Rural I stated. to the cause(c	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and manner as stated. 2 (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not detarmined 29e. CERTIFIER (Check only 000) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIFI MAYHA 30. NAME AND ADDRESS OF PERSON MAYHA LEVAL 31. DATE FILED (Month, Day, Year)	HOSPITAL: HOSPITAL: 1 Inpatient 2 El 28e. DATE OF IN. (Month, Day, 28e. PLACE OF IN. (Month, Day, 10 10 10 10 10 28e. PLACE OF IN. (Month, Day, 11 Inpatient 2 El 28e. DATE OF IN. (Month, Day, 12 13 14 15 16 13 14 16 16 16 14 16 16 16 15 16 16 16 16 16 17 16 16 18 16 16 19 16 16 19 16 16 10 16 16 10 16 16 11 16 16 12 16 16 12 16 16 13 16 16 14 16 15 16 16 16 17 16 18 16 19 16 10 16 1	SE OF DEA 26. PLAC 26. PLAC R/Outpatient 3 JURY Year) NJURY — At hor.: (Specify) A knowledge, de inination and/or I	SEASE TH YES E OF DEATH DOA 28b. TIME INJU me, ferm, st sth occurred we style of the course o	A HONO I (Check only o OTHER: 4 Nursing H OF RY M 1 [reet, factory, o I at the time, d , in my opinion	UNCERTAIN THE DESCRIPTION OF THE PROPERTY OF T	8 Other (Spec 28d. DESCRIBE 28f. LOCATION City or Tow to the cause(s): 1flme, data and p	City) E NOW INJURY (Street and Num, State) and manner as place, and dua	occured more or Rural I stated. to the cause(c	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and manner as stated. 2 (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF M	ARYLAND / DE	PARTME TIFICA				NTAL HYGIENI REG. NO.	Ē		
1	1. DECEDENT'S NAME (First, Middle, Last)	_					2.	DATE OF DEATH			3. TIME OF DEATH
- 7	ROSHNI				ALI			OV 2	2	94	9:32 pr
- 3	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birt	MONTH	DER 1 YEAR	IF UNDER 24	MIN	DATE OF BIRTH (Month, Day, Year)	- 1	8. BIRTH Country	PLACE (State or Foreign
	220-04-1430	1 □ M 2 🄀 F	46 \	rRS.			M	ay 9, 194			kistan
œ	9s. FACILITY NAME (If not institution, give s					R LOCATION				UNTY OF DEATH	
DIRECTOR	HOLY CROSS HOS	PITAL		SI	LVER	SPR	ING		MON	TGO	MERY
REC	10a, STATE 10b, COUNT	1	10	c. CITY, TOW	N OR LOCAT	ION					10d. INSIDE CITY LIMITS?
		gomery		Burton	svil.	le					1 X YES 2 NO
3AL	10e. STREET AND NUMBER				101	ZIP CODE					HAT COUNTRY?
FUNERAL	3818 Stepping Sto					20866				USA	
FU	11. MARITAL STATUS 1 Never Merried 2 Merried	FORCES? 1	EVER IN U.S. ARMED		It yes, sp	ecify Cuben,	Maxicen, P	RIGIN? (Specify Yes usrto Rican, stc.)	or No-	14. RACE Black	American Indian, Whits, stc.
B≺	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	l	1 TYES	2 💢 NO	Specify:			Specifi Pa	y: kistani
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		18s. DECED	ENT'S USUAL	OCCUPATIO	N at of working		16b. KIND OF BUS	INESS/INDI	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+) life, Do	NOT use retired	1.)			Chi	nnin		
MP	12	5+	Self	-emplo	yed p				pping	5	
8	17. FATHER'S NAME (First, Middle, Last)							First, Middle, Maiden			
BE	Khodadad Irani 198. INFORMANT'S NAME (Typo/Print)		106 M	MI INC ADDR	CP /Ptm st -		oja	Unkno	****		
임	Syed Aftab Ali							Burton			MD 20866
	20s. METHOD OF DISPOSITION		20b. PLACE AND	DATE OF DISP	OSITION (Na	ma of		DATE 20c. LOC	ATION — C	Ity or To	wn. State
	1 🗵 Burisi 2 🗆 Cremstion 3 🗀 Rem 4 🗆 Donation 5 🗀 Other (Specify)	oval from State	George	Washi	ngton	Ceme	tery	1/23 Ade1	phi,	Mar	yland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	v	:	2. NAME AN	D ADDRESS	OF FACILITY	Mines-Ri	nald	i Fu	neral Home
	Mayor K.	Grant	_					shire Ave Maryland		90%	
	29. PART i. Enter the diseases, or a shock, or heart failure.	complications that	caused the deeth.	Do not an	er the mo	da of dylng	g, auch e	cerdiac or respir	atory arre	eat,	Approximata
	IMMEDIATE CAUSE (Final					,					Interval Between Onset and Death
	disesse or condition reaulting in death)	. Pulmor	OR AS W CONSEQUEN	rambo	rem	20 (u	S				3 WKs.
		O at a	OR AS A CONSEQUEN	ICE OF):	1-00						
ON	Sequentially list conditions,	b. DUE TO	OR AS A CONSEQUEN	ICE OF):	1005	15	1				
CAT	If any, leading to immediate cause. Enter UNDERLYING	Rece	+ left	lowe	- 6	9 1	ruck	we			1
E	that initiated aventa	DUE TO	OR AS A CONSEQUEN	ICE OF):) (
CERTIFICATION	resulting in death) LAST	d									
	PART II. Other significant condition	contributing to	daath but not rasu	Iting in tha	undariying	causa giv	ven in Par			24b.	WERE AUTOPSY FINDINGS
)C								PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEC											1 YES 2 NO
ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEATH	YES	NO E	UNCE	RTAIN [
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	DEATH (Che							
IYS	1X X ES 2 ☐ NO 27. MANNER OF DEATH	1 D Inpatient 2 X	ER/Outpatient 3 🗆 🗆		luraing Hom			Other (Specify)			
	1 Natural 5 Pending	(Month, De	y, Year) (L	COLOS	28c. INJ WO	RK?		DESCRIBE HOW IN	JURY OCC	URED	20
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At home.	V-1				LOCATION (Street at	nd Number	or Rural R	oute Number,
Ë	4 Homicide determined	building,	Hc. (Specify)	ne			3	City or Town, State)	10014	Sh	me time
P.E.	29s. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge, death o	occurred at th	e time, dats	and pisce, e	ind dus to t	ne cause(s) end man	ner se atate	d.	
COMPLETED	one) 2 MEDICAL EXAMINE										and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIE	1817	1			29c. LICEN	SE NUMBER	J	29d. DATE	SIGNED	(Month, Day, Year)
TO BE		600	4			O.C	M.E		► N	OV	23.1994
۴	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS			- 01			142			
	David R Pour	16:	11.	ı Pen	n St	reet	, Ba	rrimore	, ma	LAT	and 21201

permit. Pages 1, 2, 3 should

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit p	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ENDING PHY	R: After this	er death wit	Is marke
IL DR ATTE	L DIRECTO	2 hours aft	f Item 28
HE HOSPITA	HE FUNERA	od within 72	DRTANT: II
10	10	be file	IMPC

AND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR REG NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3 TIME OF DEATH YEAR CHARLES Charles B. Allen ALLEN 94 13:07 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 🔀 M 2 🗌 F 212-66-8299 Feb. 7, 36 1958 Washington, D.C 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma PArk Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Takoma Park 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1312 Elson Place 20912 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuben, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, alc. FORCES? 1 YES 2 1 Never Married 2 Married BY 1 TYES 2 NO Specify Specify: 3 Widowed 4 Divorced White ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 4 Political Media Consultant Self-Employed 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas F. Allen Dolores Morganston BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Dolores E. Allen 1312 Elson Place, Takoma Park, Maryland 20912 20a. METHOD OF DISPOSITION
1 M Burial 2 Cremation 3 Removal from State 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Glenwood Cemetery 4 Donation 6 Other (Specify) 11/28 Washington, D.C. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, MD 23. PART i. Enter tha diseases, or complications that ceused tha daeth. Do not anter tha moda of dying, auch es cerdiec or respiretory errest, Approximata shock, or heart failura. List only one ceuse on each line interval Between IMMEDIATE CAUSE (Final Onset and Death diseese or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in daath) (neumory ware Kan (a PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF if any, laeding to immedieta cause. Enter UNDERLYING CAUSE (Disease or Injury andrum OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aigniticant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 5 NO OEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\text{N}}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCUREO 1 Natural 5 Pending 1 YES 2 NO ВУ 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Nomicide determined 29a, CERTIFIER 1 📈 CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated, 296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 8 29d. OATE SIGNED (Month Day Year) lun 11 23 9 4 d. 2 PAL NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print, RADES RIVASTAUA, 20 2070 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Lulia Davidson

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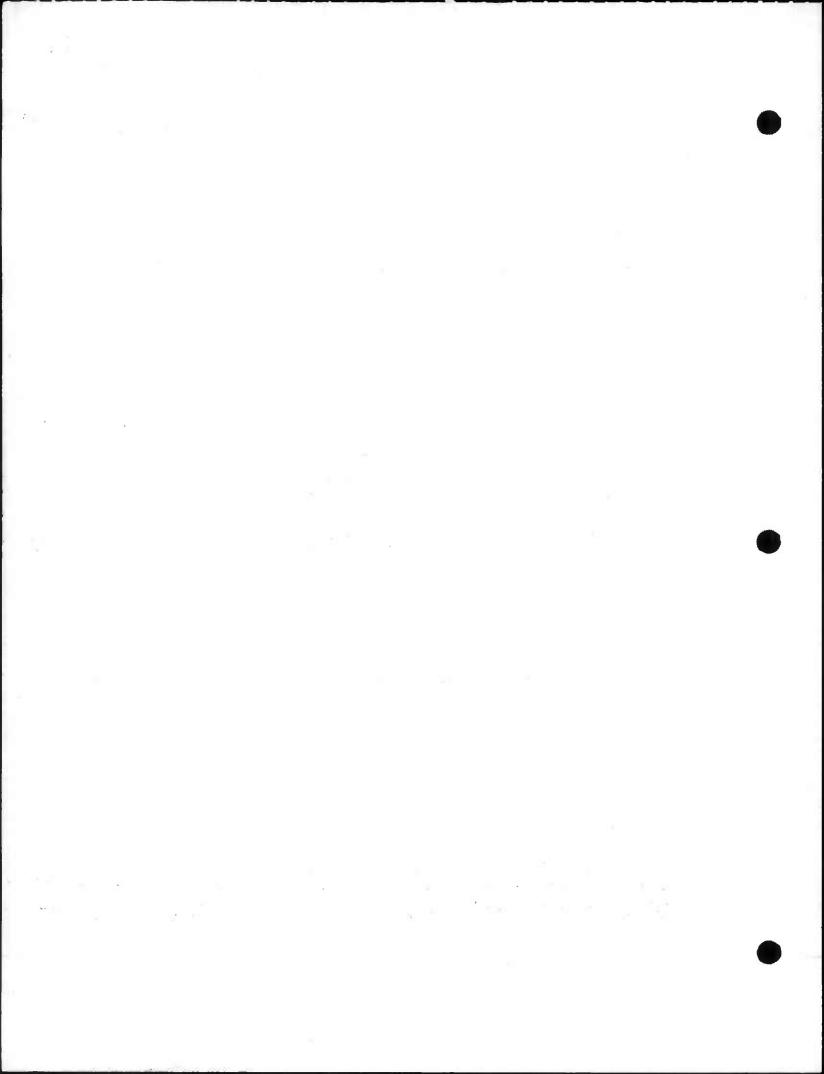
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lag 2. DAJE OF DEATH 3. TIME OF DEATH -1LOMENA TONUCCI 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 1 M 2 045-14-3988 YRS. Jan. 1, 1909 Connecticut 9e. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Malcolm Grow Medical Center DIRECTOR Prince George's Camp Springs RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY New Haven Connecticut New Haven t XYES 2 NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 06513 United States 311 Eastern Street, Bldg. E Apt. 1516 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuben, Mexicen, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: Specify: White BY 3 X Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementery/Secondary (0-12) College (1-4 or 5+) Seamstress Garment 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE Unknown Piscitelli Marianna Unknown 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Anna D'Agostino 30 Cottontail Lane, North Haven, Connecticut 06473 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) NOV 29, 1994 20e. METHOD OF DISPOSITION
1 № Burlel 2 □ Cremetion 3 □ Removal from State New Haven, Connecticut DATE cremetory or other place) Nov. 29 Lawrence Cemetery 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Bethesda/ Chevy Chase Funeral Home, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 Welman Jerta M00202 Funeral Home, Inc. 7557 Wiscon Bethesda, Maryland 20814-3501

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. intarvai Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition rteriorcleratic cardiovas resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO arthulis untrac COMPLETION OF CAUSE 1 - YES 2 40 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only or EXAMINER? OTHER-1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY t Natural M 1 YES 2 NO BY investigation Accident 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e, CERTIFIER

1 A CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner as stated. MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER age. LICENSE NUMBER 29th DATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 12. REGISTRAR'S SIGNATURE Lulia Davidson

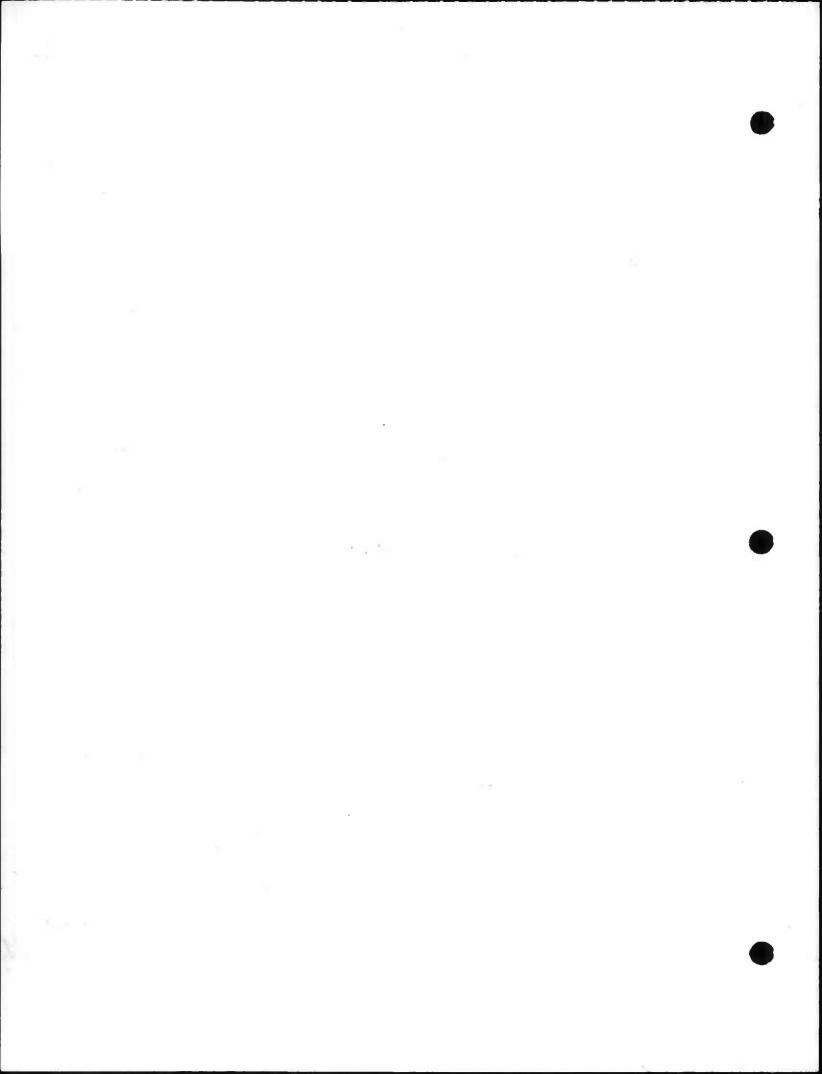


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within explores that death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

REGISTRAR				CERI	IFIC	AIE	OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First,	Middle, Last)								OF DEATH			3. TIME OF DEATH
SANTO	S			ALEMA	N			NO	V.01,	1994	YEAR	09:06 A M
4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE ((In yrs. last birtho	day) IF	UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE	OF BIRTH			IPLACE (State or Foreign
UNAVAILABLE		1▼ M 2 □ F	28	YF	IS. MO	NTHS DA	YS HOURS MIN.	(Mon	th, Day Year) 6	5	Countr	γ)
9a. FACILITY NAME (If not in		treet and number)			94	CITY TO	WN OR LOCATION OF D				NTY OF D	SALVADOR
5500 BLK.		,			6		ATON	EAIH				
RESIDENCE OF DEC		NE PL.				WIL	AION			MC	DNTG	OMERY
10a. STATE	10b. COUNT	γ		10c.	CITY, T	OWN OR LO	CATION					10d, INSIDE CITY
MD	MONTO	OMERY			HEA'							LIMITS?
10e. STREET AND NUMBER	HONTE	OPILIKI			TILITY.	1011						1 X YES 2 NO
							10f. ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?
A11500 AMHE	RST AV						20902			EL S	SALVA	DOR
11. MARITAL STATUS 1) Never Married 2	***	12. WAS DECEDENT FORCES? 1 [EVER II	N U.S. ARMED			DECENDENT OF HISPA , specify Cuban, Maxic			or No-	14. RACE	— American Indian, k, White, alc.
3 Widowed 4 Olvo		IF YES, GIVE WA					YES 2 NO Speci		rican, aton	- 1	Speci	tty:
						<u> </u>					HISE	PANIC
15. DEC (Specify only	EDENT'S EDU	CATION completed)		18a. DECEDEN (Give kind	d of work	done during	PATION a most of working	16	b. KIND OF BUS	SINESS/INC	DUSTRY	
Elementary/Secondary (0	-12)	College (1-4 or 5+)		life. Do No	OT use re	tired.)						
6TH				UNEMP	LOY	ED			NONE			
17. FATHER'S NAME (First, M	iddle, Last)						18. MOTNER'S N	AME (First,	Middle, Maiden	Sumame)		
JOSE ADAN A	VILA						GREGOR	IA A	LEMAN			
19a. INFORMANT'S NAME (7)				19b. MAII	LING AD	DRESS (Str	eet and Number or Rural	Route Nun	ber, City or Tow	n. State. Zic	Gode)	
PEDRO ALEMA	N						RST AVE,#1					2
20a. METNOD OF DISPOSIT			206	PLACE AND D				OAT		CATION —		
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21. SIGNATURE OF FUNERA	_	ENGEE	GI	TEMMOOL	CE						-	J.
21. SIGNATORE OF TORERA	777	0				W. H.	BACON FU	NERA	L HOME	INC		
we	W.	Kara	7	276			7 14TH STR					20010
23. PART I. Enter the di	seesea, or o	omplications that	caused	the death. I	Do not							Approximate
ehock, or he	eert fallure.	List only one caus	е оп е	ech line.			mode of dying, ad	ou car	olec of Teepi	latory and	reet,	Intervel Batween
IMMEDIATE CAUSE (Fin	ial .											
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disease or condition resulting in deeth)	→					COLOG	IC CAUSE	OF DE	EATH			Onset and Death
disease or condition	+			C OR TO		COLOG	IC CAUSE (OF DI	EATH			Onset and Death
disease or condition resulting in deeth)		DUE TO (OR AS A	CONSEQUENC	E OF):	COLOG	IC CAUSE (OF DE	EATH			Onset and Death
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be found after that the state Dept. of Health and Memai Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	REGISTRAR		ERTIFICA	IL OL	DEATH	REG. NO.						
	1. OECEDENT'S NAME (First, Middle, Last)	050500				2. DATE OF DEATH	ر ۲	(EAR) 3. TIME OF DEATH P				
	JOMES T. HOT 4. SOCIAL SECURITY NUMBER 5. SEX	DERSON				11 2	7 .	141 10 "				
	- Film	_	YRS. WONT	THS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
- 1	190-12-0190 NAXM 90. FACILITY NAME (If not institution, give street end i	04	-	OITY TOUR! O		March 6,	1910					
Œ	1	1 11	:7 / 20.	E II	R LOCATION OF DEA	AIH	9c. COUNT	Y OF DEATH				
18	TOUSTON GENE	iai mosp	ITall	ICH	21010		TH	KTORU				
DIRECTOR	10e. STATE 10b. COUNTY	20	10c. CITY, TO	WN OR LOCATI	ON			10d. INSIDE CITY				
		ork	De1	.ta				1 ☐ YES ★ 1 NO				
ERAL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?				
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	unknown	(1~4 Of 5+)	armer			Agri	cultu	ıre				
ONCE.	17. FATHER'S NAME (First, Middle, Last)			T	18. MOTHER'S NAM	NE (First, Middle, Maiden						
를 U	Scott Anders	son		1	Bessie	Ruff	,					
iffed a	19e. INFORMANT'S NAME (Type/Print)		b. MAILING ADDI	RESS (Street an		oute Number, City or Town	n, State, Zip Co	ode)				
1 1	Genevieve M. Ande:	1				a, PA., 1						
2	20e. METHOD OF DISPOSITION	20b.PLACE	AND DATE OF DIS	POSITION (Nan		1	-	y or Town, State				
Ē	1 Donation 5 Other (Specify)		t.owne	ace)	1	1/29 Yor	k, PA	١.				
in a	21. SIGNATURE AF FUNERAL SERVICE LICENSEE	-511.1			O ADDRESS OF FAC			15014				
еха	1 Change Hold	litt		Harki	ins F.H	.Inc., D	elta,	PA.,17314				
ca	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, Approximate											
E	anock, or neert reliure. List only	y one ceuse on each line	L.		,			interval Between				
ž.	IMMEDIATE CAUSE (Finel disease or condition Onset and Death											
E,	resulting in death)	DUE TO (OR ASIA CONSEC	DUENCE OF	10(00	744	- 13						
ws any Injury, or other traumatic event, the medical examiner must be notified at once. EDICAL CERTIFICATION TO BE COM	- ('·	on ger time	1+0	art	Faile	ive						
	Sequentially list conditiona, if any, leading to immediate	DUE TO YOR AS A CONSEC	DUENCE OF):									
r other traumatic	CAUSE (Disease or injury	SCVD										
	thet initieted events resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF):									
CER P	d											
튑기	PART II. Other significent conditions contri	buting to death but not r	resulting in the	e underlying	cause given in P	Part I. 24a. WAS AN.		24b. WERE AUTOPSY FINDINGS				
DICAL						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE				
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SICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLAC	E OF DEATH (Ch		OT TOERT AND							
SICI/		PITAL: patient 2 ER/Outpetient 3		HER: Nursing Homa	5 Residence 8	Other (Specify)						
PHY		e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	IRY AT	28d. DESCRIBE HOW IF	JURY OCCUP	RED				
marked, BY PH	t Natural 5 Pending 2 Accident Investigation	(monn, buy, rouly	I	M 1 TY	ES 2 NO							
<u>∞</u> □	3 Suicide 8 Could not be	e. PLACE OF INJURY — At ho building, etc. (Specify)	me, farm, street.	factory, office		281. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,				
1 28 TE	4 Homicide determined					only or lown, orato)						
P	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To	the best of my knowledge, de	ath occurred at t	the time, data e	end place, end dua t	o the ceuse(s) and men	ner ea stated.					
COMPLET	one) 2 MEDICAL EXAMINER: Dn the											
€ ω	296. SKINATURE AND TITLE OF CERTIFIER	TAAAA		T	29c. LICENSE NUME	BER	29d. DATE S	IGNED (Month, Day, Year)				
B	Semmi	VVV			H410	69	► Ll	129/04				
\$ 2	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CAUSE OF DEATH (ITER	M 27) (Type, Print)					1 17				
	STANLEY KMAN	1308 Bus	INESS	WAY.	# 102,	EDGEW	A. Go	D. 21040				
	31. DATE FILED (Month, Day, Year) 1994 32.	AEGISTRAS SIGNATURA	refall.	,								
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

	REGISTRAN		- 0	LITTI	CALE	OI.	DLA			HE	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	Anna	Rae		BROWN				M	DATE OF DI	DA	, 19	YEAR Q/	3. TIME (OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. la:		IF UNDER 1		IF UNDER	24 1405	7.0	ATE OF BU	OTH	1 15			tate or Foreign
	232-72-9527	1 □ M 2 🕅 F	49	YRS.		DAYS	HOURE	MIN.	, (A	Month, Day,	Year)	10/5	Count	(vr)	_
	9a. FACILITY NAME (If not institution, give st	(reet and number)			9b. CITY, 1	TOWN O	R LOCATIO	ON OF DE		. J	1, .		NTY OF D		ginia
œ	610 Lee Place	root and namesty					rick		AIN						
6	RESIDENCE OF DECEDENT				FL	eae.	LICK					Fr	eder	1CK	
Ö	10a. STATE 10b. COUNTY	1		t0c. CIT	, TOWN OR	LOCAT	ION							10d. INSI	DE CITY
DIRECTOR	Maryland Fre	derick			Fred	eri	c]c							LIMI	TS? S 2 NO
7	10e. STREET AND NUMBER				TTCa	_	ZIP CODE					too. CIT	ZEN OF V	WHAT COU	
FUNERAL	610 Lee Place						2170								
N.	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN II S AD	MED	1 12 14	Le DEC			110 OF	RIGIN? (Spe	и и		J.S.		
	1 Never Married 2 Merried	FORCES? 1	YES 2 X	NO	11 1	yes, spe	cify Cuba	n, Mexicas	n, Pue	erto Rican,		or No	Blac	E — Americ k, White, at	tc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 1 [YES	2 XNO	Specify	r:				Spec	"y: Whi	te
0	15. DECEDENT'S EDUC		16a, DE	CEDENT'S	USUAL OCC	UPATIO	N .		Т	16b. KIND	OF BUS	INESS/INI			
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(G	ive kind of v . Do NOT us	rork done du e retired.)	ring mos	at of workin	g	- 1		-,				
4	Lientenary obtaining (U-12)	2	Chi	1d Ca	re Pr	ovi	der		- 1	Ch	i1d	Care	2		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAI	ME (Fi	irst, Middle,					
		Harmon	R	OPER				eta			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		RHAR	PT.	
BE	19e. INFORMANT'S NAME (Type/Print)	****			ADDRESS (Street #			Pourte 1	Number Cir	v or Tour			**	
2	Mr. Raymond S. Bro	own	1		e Pla								0000)		
	20a, METHOD OF DISPOSITION		20b. PLACE					eder J	7			ATION —	0h T	- 01.1	
	1 Burial 2XXCremation 3 Ramo	oval from Stata	compton, cre	maton, or of	hor place!			-	1						
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	restn	aven	M€M.	Gar	dens D ADDRES	, De	CULTY	1,19	94 F	rede	rick	Ma	ryland
	4. 0	(6 2	1,000	500						P.A	. Fi	mera	1 H	ome.	
	Allan X	Ruby	MOO	703	106	Ea	ast C	hurc	ch	St.,	Fre	ederi	.ck	Md.	21701
	23. PART I. Enter the diseases, or c ehock, or heart feilure. I	omplications that c	eused the de	eth. Do n	ot enter th	ne mod	de of dyl	ng, auct	h aa	cerdiac o	r reepli	ratory an	reat,	App	proximata
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cardificate be executed within

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Alicidia (not)			OLITTI	OAIL	JI DEAL	''	HEG. NO		Τ.	
	WILLI		BRUC	UEV				7		AY	YEAR	18:45
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In:				e last hirthclau)	IF UNDER 1 YE	AR IF UNDER 2		cember 1,	1994		ACE (State or Foreign
	220-03-143	4	1 M 2 D F	76	YRS.	MONTHS DA			Month, Day, Year) Sept. 15,	1918	Country)	
	9e. FACILITY NAME (If not in		-	70	9b. CITY, TOWN OR LOCATION OF DEATH					MAI TY OF DEA	yland	
<u>د</u>	Frederick		,	ital			erick	N OF DE	an.			
ECTOR	RESIDENCE OF DEC			Lear		TTEU	ELICK			Fre	ederi	CK
H	10e. STATE	10b. COUNTY			10c. CIT	, TOWN OR L	OCATION				10	Dd. INSIDE CITY
DIR	Maryland		lerick		T	nurmon	t				1	YES 2 NO
IAL	10e. STREET AND NUMBER						101. ZIP CODE			10g. CITIZ	ZEN OF WH	AT COUNTRY?
ÉR	9 Sunny I	Way					21788	3		Unit	ed St	tates
FUN	11, MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES 2	NO NO				C ORIGIN? (Specify Ye., Puerto Rican, etc.)	or No-	14. RACE - Black, V	- Americen Indian, White, etc.
l a l	3 Widowed 4 Dive		IF YES, GIVE Y	VAR OR DATES			YES 2 NO				Specify:	White
8	15. DEC	EDENT'S EDUC		180	DECEDENT'S	IISHAL OCCU	PATION		16b. KIND OF BU	SINESS (IND	HETEV	WILLE
1	(Specify only highest grade completed)				(Give kind of a life. Do NOT us	rork done durin	g most of working	3	IOU. KIND OF BU	SINESS/IND	OSTAT	
	Elementary/Secondary (0-12) College (1-4 or 5+)				Lá	borer			Buil	ding		
COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	ER'S NAM	IE (First, Middle, Maiden			
ш	William I). Bru	chey				Ru	th	Irene Co	oker1	v	
0 8	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Str	eet and Number o		oute Number, City or Tow			
1	Donald L.	Bruche	у		9 Sur	iny War	Thur	mont	. Marylan	d 21	788	
	20e. METHOD OF DISPOSIT	ION on 3 □ Remo	val from State	20b. PL/	CEANDDATE	E DISPOSITIO	M (Name of		DATE 200 LC	CATION - (City or Town	, State
	1 Burlet 2 Cremetton 3 Removal from State Cemetery, crematory or other place Hagerstown Crematory 12/4/94 Hagerstown Maryla											Marylan
	22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funer 104 East Main Street Thurmont 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										nt. M	D 21788	
П	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
1 1	Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Interval Between Onset and Des Onset											
	disease or condition	→	ASP	RAT	NOI	PNE	UMO	Wi	A			2 WEFK
	readiting in death)	11.9	DUE TO	(OR AS A CO	NSEQUENCE OF	7).						
Z	Sequentially list condit	lone 6	BRM	NSTE	EMIN	FARC	1					& With
Ĕ	if any, leading to imme	diete	DUE TO	(OR AS A CO	NSEQUENCE OF	7):						
2	CAUSE (Disease or Injury											
ERTIFICATION	that initieted events reaulting in deeth) LAS	ST	DOE 10	(OH AS A CO	NSEODENCE OF).						
B		0	•									+
A	PART II. Other significe	ent conditione	contributing to	deeth but r	not resulting	n the under	lying ceuse gi	iven in P	Part I. 24a. WAS AN			ERE AUTOPSY FINDING
EDICAL CI	<u> </u>	· +		_					1 YES 2	. /	C	OMPLETION OF CAUSE F DEATH?
ME	C.M.	<u>r</u>						1	_			YES 2 NO
ä	DID TOBACC	O USE	CONTRIBUT	E TO C	AUSE OI	DEATH	YES 🔽	NC				
SICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEOICAL	HØSPITAL:			OTHER:	6. PLACE OF DE	ATH (Chec	ck only one)			
X	1 YES 2 NO		1 Dinpatient 2			4 - Nursing		_	Other (Specify)			
РНУ	27. MANNER OF DEATH 1 Natural 5	Pending	28e. DATE OF (Month, D	lay, Year)		b. TIME OF 18. TIM						
à l	2 Accident	Investigation	26a BLACE C	E IN HIOV	them to		YES 2					
B	3 Sulcide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street building, stc. (Specify)						m, street, fectory, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)					
	290. CERTIFIER	description of					III					
COMPL	(Check only								o the cause(a) and ma			
8	2 MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my opinion, death occurred at the time, date as											
O BE COMP	296. SKANTURE AND TITLE	OF CERTIFIED					29c. LICEN	NSE NUMI	BER	29d. DATE	SIGNED (M	fonth, Day, Year)
임	30. NAME AND ADDRESS D	PERSON WUO	COMPLETED CALL	SE OF DEATH	(ITEM 27) /T	(Palest)				10	444	4
	V 9	R. L	COMPLETED CAU	SE OF DEATH	(IIEM 27) (N/Pe,		11	A	7-1		1.1	A
	31. DATE FILED (Month, Day,	1)aK	32. REGISTER	R'S SIGNATUI	801		House	Avi	e Frede	rick	M	0 2170
	DEC	0 5 199		. Danel	war Rarda	10.						
	UEU	0 0 133	19 19	- comme	who willedge	46						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely lime be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation,

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

IMPORTANT: If Item 28 is marked, or

	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH
	MABEL J. BRICK "12 2 94 63"
н	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) MANY Page Mounts Page Page Mounts Page
	059-22-74810 M 2 DF 94 YRS. MONTHS DAYS HOURS MIN. 2-12-1800 COUNTRY) PA
	Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION DF DEATH 9c. COUNTY DF DEATH
CTOR	Chesapeake Manor NH Arnold At.H.
ш	10e. STATE 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY
	MD AA. Anold 1 YES 2 SAND
A P	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?
FUNER	1021 placed of 21012 USA
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED 13. WAS DECENDENT DF HISPANIC DRIGIN? (Specify Yee or No— 14. RACE — American Indian, Black, White, etc.) 14. RACE — American Indian, Black, White, etc.)
B	1 Never Merried 2 Merried 1 FYES, GIVE WAR OR DATES 1 VES 2 MIN Specify: Sp
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working
PLET	Elementary Secondary (0-12) College (1-4 or 5+) life. Po WOT use retired.) Me unaker (-12) College (1-4 or 5+)
BE COMPL	17. FATHER'S NAME (First, Middle, Leet) Prentice 16. MOTHER'S NAME (First, Middle, Meiden Surname) Ext Chamberlain
10	19a. INFORMANT'S NAME (Type/Print) Tames Brick 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Same AJ ALO
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE DF DISPOSITION (Name of cemetery, crematory or other place) 5 Dhys Cem (2-8-94 Significance, PA
	22. NAME AND ADDRESS OF FACILITY Bayana Sevena Park MO
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

IMMEDIATE CAUSE (Final

disesse or condition resulting in death)

DUE TO (OR AS A CONSEDUENCE DF):

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Onset and Death

1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL **FYAMINER?** 1 YES 2 NO

27. MANNER OF DEATH

Accident

3 Sulcide

4 Homicide

HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 28e. DATE OF INJURY (Month, Day, Year)

28c, INJURY AT WORK? 28b. TIME OF INJURY

me 5 - Residence 8 - Other (Specify) 28d, DESCRIBE HOW INJURY OCCURED

28e. PLACE DF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(a) end manner se stated.

295 WIGNATURE AND TITLE OF CERTIFIER

8 Could not be determined

29c. LICENSE NUMBER 141339

26. PLACE OF DEATH (Check only one)

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

38. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ARNOLD, mo 279 JAMIE (HARMS PENINSULA FARM RD

31. DATE FILED (Month, Day, Year)

32. BEGISTRAR'S SIGNATURE Whi Davidson Randall

DHMH-16 Rev 1/89

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BOX 68	
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thicate be executed within 24 hours after death. Page 6	JR. After this certificate ha	iene prior to burial, cremation, or removal,	IMPORTANT If item 28 is marked as Item 22 shows any interest as a the marking assembled as a state of a second

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FOR STATE REGISTRAR STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DOROTHY PROBITSKY BLACKMAN NOVEMBER 28,1994 4:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign APRIL 20,1908 102-09-6658 1 M 2 X F 86 YRS. MASSACHUSETTS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH COLLINGSWOOD NURSING HOME ROCKVILLE DIRECTOR MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY ROCKVILLE 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5329 NORBECK ROAD 20853 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 MINO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: ☐ Never Married 2 ☐ Married Specify: WHITE A 3 X Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) COMPL BOOKKEEPER DRY GOODS 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname ISRAEL PROBITSKY LENA LOEB BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 5329 NORBECK ROAD - ROCKVILLE, MARYLAND 20853 NATALIE KIRSCHBAUM (NIECE) 20s. METHOD OF DISPOSITION
1A Burlal 2 Cremation 3A Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE NEW MONTEFIORE CEMETERY 4 Donation 5 Other (Specify) 11/29 PINELAWN, NEW YORK 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch sa cardisc or reapiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finsi Onset and Death disease or condition resulting in death) eneci CERTIFICATION Sequentially list conditions, AS A CONSEQUENCE OF If any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? perlensin 1 TYES 2 TANO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER:
4 A Nursing Home 5 A Raaldenca 6 Other (Specify) HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural м 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(a) end manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) theaming . 17.1) 021662 30. NAME AND ADDRESS OF PENSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILHELMINA G. CAMINA - 4912 ADRIAN STREET, ROCKVILLE, MARYLAND 20853 32. SEGISTRAN'S SIGNATURE Pandelle 0

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner as stated.

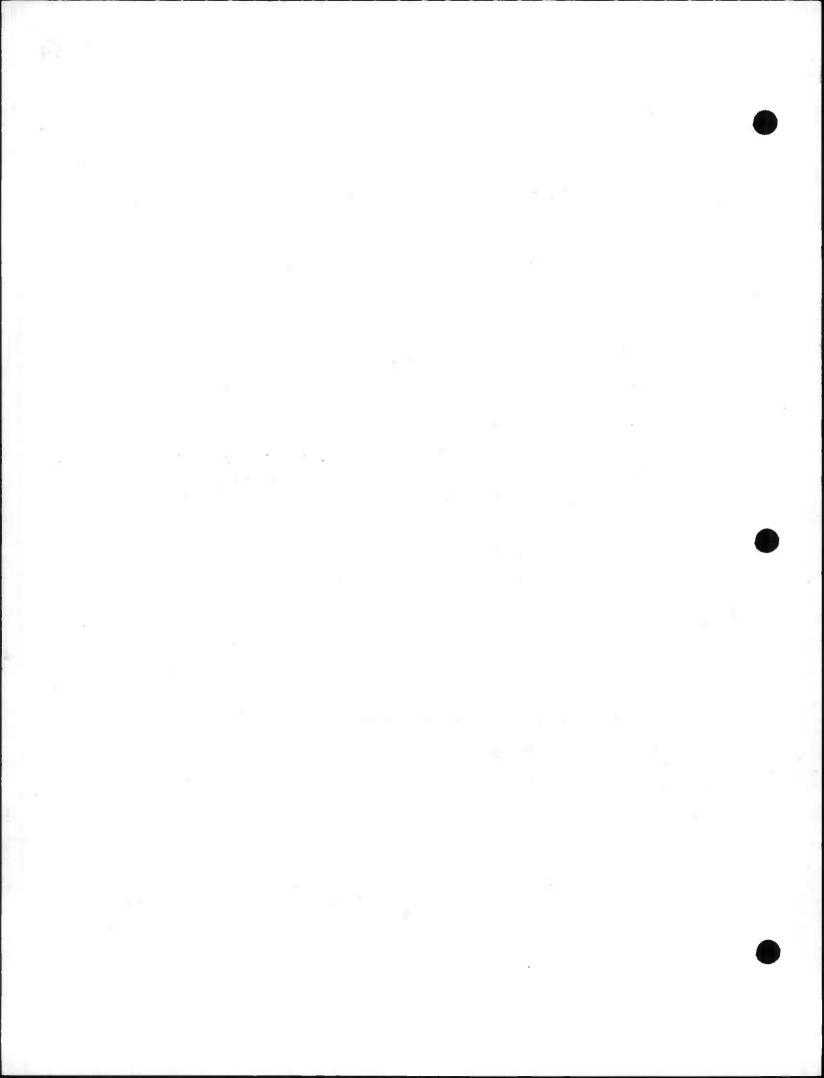
BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND REGISTRAR		RITMENT OF H		MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last) GEORGE EUGENE	- B	UTLE	R	2. DATE OF OEATH DA		3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs.	SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF RIG					IPLACE (State or Foreign			
	219-80-0445 1X M 2 F 26 9a. FACILITY NAME (If not institution, give street and number)	YRS.		PR LOCATION OF DE	Jan. 30,	1968	Maryland			
TOR	Washington County Hospita	1		rstown	AID	A	NGTON			
DIRECTOR	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?			
	Maryland Montgmery 100. STREET AND NUMBER	V	Meaton	ZIP CODE		10g. CITIZEN OF	1 X YES 2 NO			
FUNERAL	12120 Valleywood Drive			2090	2	U.S				
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		It yes, sp	ENDENT OF HISPAN pcify Cuban, Mexicer 2 X NO Specify	IC ORIGIN? (Specify Yes n, Puarto Rican, etc.)	Blac	E — American Indian, k, White, atc. thy: Black			
TED	(Specify only highest grade completed)	(Give kind of	USUAL OCCUPATION	DN st of working	16b. KIND OF BUS	INESS/INDUSTRY				
COMPLETED	Elementery/Secondary (0-12) College (1-4 or 5+)	Labo	4 101-		No	ne				
	17. FATHER'S NAME (First, Middle, Last) Crammer Butler	-			ME (First, Middle, Maiden :	Surname)				
TO BE				nd Number or Rural R	loute Number, City or Town					
٦	The second of th				r., Whea					
		rematory or o	of disposition (Na other place) orial Co	emetery		andy Sp	ring, MD			
	21. SIGHATUMENT PUMERAL SERVICE LICENSTE PROMISE	leu	22. NAME AN	ID ADDRESS OF FAC	NERAL HO	ME, P.A				
	23. PART I. Enter the diseases, or complications that caused the a shock, or heart fellure. List only one cause on each lie	deeth. Do i	not enter the mo	de of dying, such	es cerdiec or respi	ratory arrest,	Approximate Interval Between			
	IMMEDIATE CAUSE (Fine)		Fuju	uy c	rul		Onset and Death			
z	disease or condition a. Close & Head Fujury and Sylvary Due to (or as a consequence of): Neljor Chast & Ofbdommid Trouma									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	EQUENCE O	F):							
IFIC	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONS	EQUENCE O	F):							
EE	resulting in deeth) LAST									
AL	PART II. Other significent conditions contributing to death but not	resulting	In the underlying	ceuse given in i	Pert I. 24a. WAS AN . PERFOR		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
PHYSICIAN: MEDIC			-		1 [] YES 2	B-HO"	COMPLETION DF CAUSE OF DEATH?			
N.	DID TOBACCO USE CONTRIBUTE TO CA	USE OI	F DEATH	ES NO			1 TYES 2 NO			
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		28. PL OTHER:	ACE OF DEATH (Che	ck only one)					
HYS	1	28b. TIM	E OF 28c. INJ	e 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW IF	JURY OCCURED				
ВУР	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	00.	30M 101		174 to 17	cciden	6			
	3 Suicide 8 Could not be 4 Homicide 8 Could not be detarmined R+#34	home, farm,	,	/	28t. LOCATION (Street a City or Town, State)	nd Number or Aural	Route Number,			
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge,	death occurr	ed at the time, date	and place, and due	to the cause(a) and man	ner as stated.				
CON	one) 2 MEDICAL EXAMINER: On the basis of examination and/o	r investigatio	on, in my opinion, d	eath occured at the	time, data and pieca, and	due to the cause(a) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	-6~		10 - / O	10	≥ 11 (2	(Month, Day, Year)			
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	EM 27) (Type	2	w.wo.	Phuston	2/24	5			
	31. DATE FILED (Month, Day, Year) 32. REGISTRAN'S SIGNATURE		Nace	7300W	u, re	AIIE	U			
	NOV 3 N 1994 Julia Davidson	Mandell	2							



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DFC 0 2 1994

Julia Daydson-Randell

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OFATH 3. TIME OF DEATH PERRY 994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER I YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (Steta or Foreign 217-32-1069 -A 208-62-0011 DAYS 9,1904 1 M 2 - F HOURS 90 YRS Maryland June permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF GEATH DIRECTOR Holy Cross Hospital Silver Spring MONTGOMERY IOA STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Brinklow Maryland Montgomery 1 XYES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 18610 New Hampshire Ave. 20862 U.S.A. use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 XNO BY Specify Specify: Black 3 🕅 Widowed 4 🗌 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S FOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high for Elementary/Secondary (0-12) College (1-4 or 5 +) detached 5th Farmer Farm once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Pe Mary A. Thomas 百 John E. Brown BE notified funeral director, page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 20862 18610 New Hampshire Ave., Brinklow, MD 2 Martha Rheubotton (Saughter) 20 pe 20a. METHOD OF DISPOSITION
1 Cambridge 2 Cremation 3 Removal from State urs after death. Page 6 may 20c. LOCATION - City or Town, State
Highland, MD 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 12/5 "Hopkins" Church Cem. 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NOWDEN "FUNERAL HOME, P.A. Seorg 20850 ROCKVILLE, MD completely filled in by the rial, cremation, or removal. medical 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ehock, or heert failure. Liet only one ceuse on eech line interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death the diseese or condition resulting in death) TE TO JOR AN A CONSEQUENCE OF as event, executed withi and com burial, (oronary artery traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 if eny, leeding to immediate cause. Enter UNDERLYING the attending physician a death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initieted events reauiting in daeth) LAST 10 Injury, PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. requires that the 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL signed by the PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO Shows 1 YES 2 NO been to PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN; The law r FUNERAL DIRECTOR: After this certificate has be within 72 hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, office building, etc. (Specify) 99 3 Sulcide 261. LOCATION (Street and Number or Rural Routs Number, City or Town, State) COMPLETED S Could not be 28 4 Homicide Item 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner ea stated. THE HOSPITAL OTHER THE FUNERAL DE = 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) end menner ea stated. TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: 1 296. SIGNATURE AND TITLE DE CONTURER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, I

TO BE COMPLETED BY FUNERAL DIRECTOR

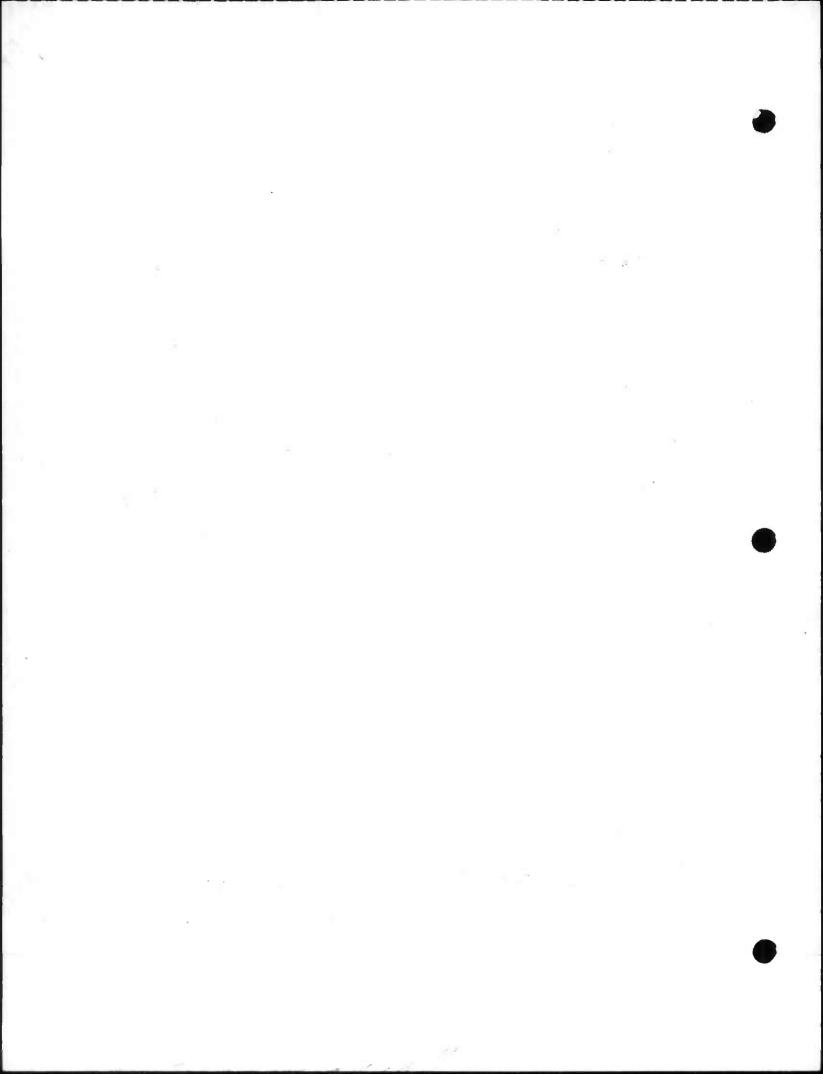
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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cian.	Il-transit permit Pages 1.2.3 should			
PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit Panes 1.2.3 should		otified at once.	
ours after death. Page 6 may be r	filled in by the funeral director, page 5	lion, or removal.	the medical examiner must be n	
the death certificate be executed within	y the attending physician and completely	h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	I, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
JING PHYSICIAN: The law requires that	After this certificate has been signed by	er death with the State Dept. of Health an	marked, or item 23 shows any	
TO THE HOSPITAL OR ATTENDING R	TO THE FUNERAL DIRECTOR:	be fixed withful 72 pours after of	IMPORTANT: If Imm 28 is marked,	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
1. DECEDENT'S NAME (First	, Middle, Last)		-				2. DATE OF DEATH 3. TIME OF DEATH				
Fernando	Ε.	Bori					NOV			YEAR QQ/	0 10 111
4. SOCIAL SECURITY NUME		5. SEX 6. AC	GE (In yrs. las	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	F IMPER 24 HRS 7 DATE OF BIRTH 8 BIRTHRI ACE (S)				
212-78-809		1 M 2 F	51	YRS.	NONTHS DAYS	HOURS MIN. Jan. 6, 1943 Spain					
10504 Ins						OR LOCATION OF O			9c. COUN	ITY OF DI	EATN
RESIDENCE OF DEC					Silv	er Spring	3		Mc	ontgo	omery
10a. STATE	10b. COUNTY			10c. CITY,	TOWN OR LO	ATION					10d. INSIDE CITY
MD	Montg	omery		S	ilver	Spring					LIMITS?
10a. STREET AND NUMBER						IOF. ZIP CODE			10a CITI	ZEN OE W	HAT COUNTRY?
10504 Ins	sley St	reet				20902					s U.S.
11. MARITAL STATUS		12. WAS DECEDENT EVE	R IN U.S. AB	MED	13. WAS D	ECENDENT OF HISPAI	NIC ORIGII	N? (Specify Yes	or No —	14. RACE	— American Indian,
1 News Married 2		FORCES? 1 Y		40	If yea,	apecify Cuban, Maxica ES 2 NO Specif	en, Puerto	Rican, etc.)		Black Specif	, White, etc.
3 Widowed 4 Divo	erced	W-24/20/2020				Spanish	·,·			эрвсп	White
15. DEC (Specify only	EDENT'S EDUCA y highest grade of	ATION omoleted)	16a. DE	CEOENT'S U	SUAL OCCUPA	TION most of working	168	. KIND OF BUS	SINESS/IND	USTRY	
Elementary/Secondary (0		College (1-4 or 5+)	life.	Do NOT use	retired.)			Print	ino		
		2		maste	r Prin	cer					
17. FATHER'S NAME (First, M						18. MOTNER'S NA					
Vicente Bo	rı					Arace	li E	scurri	o1		
19a. INFORMANT'S NAME (7	ype/Print)		191			t and Number or Rural					
Luis Bori				9823	East	Light Dri	ve,	Silver	Spri	ng,	MD 20903
20a. METNOD OF DISPOSITI	ION	val trom State	20b. PLACE	AND DATE OF	DISPOSITION		DAT		CATION —		
4 Donation S Cother		THE ROLL OF THE PARTY OF THE PA	Gat	e of i	r plece) leaven	11/30	/94	Si	lver	Spri	ng, MD
21. SIGNATURE OF TUNERA	L SERVICE LICE	NSEE //	200			AND ADDRESS OF FA					
Merry	Mon	T-412	100	m	Hin	es-Rinald	i Fu	neral	Home		6 1 15
23. PART I. Enter the di	Iseeses or co	molications that caus	end the de	eth Do no							Spring MD
shock, or h	eert fellure. L	let only Dne ceuee or	eech line	. DO 110	t enter the h	lode or dying, suc	in aa can	diac or respi	ratory erro	eat,	Approximate Interval Between
IMMEDIATE CAUSE (Fir disease or condition	nel		_		, "						Onset and Death
resulting in deeth)	→ .	<i>N</i>	espei	rayou	y D	ulure					
		OUE TO (OR A	S A CONSEC	DUENCE OF):		reluce					
Sequentially liet conditi		DUE TO (OR A	CA CONSE	WELCE OF	Cau	cinon	14 (of m	mg		
If any, leading to imme- cause. Enter UNDERLYI		50E 10 (011 A	a A CONSEC	ZUENCE OF).]		
CAUSE (Disease or Inju		DUE TO (OR A	S A CONSEC	DUENCE OF:							
resulting in death) LAS	т	, , , , , , , , , , , , , , , , , , , ,									
	d.										
PART II. Other algnifice	nt conditions	contributing to deeth	but not r	eeulting in	the underly	ng ceuee given in	Part I.	24s. WAS AN		24b.	WERE AUTOPSY FINOINGS
								PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
					_			/	7		OF DEATH?
DID TOBACCO U	SE CONTR	BUTE TO CAUSE	OF DEA	TH YES	Пио	UNCERTAIL	\square	•			
25. WAS CASE REFERRED TO					(Check only on						
1 YES 2 NO		HOSPITAL: 1 Inputient 2 ER/0	utpatient 3		OTHER:	me 5X Residence	6 (Other	e (Ensoibe)			
27. MANNER OF DEATH		28a. OATE OF INJUR	TY .	28b. TIME	OF 28c, I	JUNY AT		SCRIBE NOW I	NJURY OCC	URFO	
	Pending	(Month, Day, Yea	7)	INJUF	4.0	YQÁK? YES 2 ☐ NO	100000				
28a PLACE OF IN HIEV — At home form shoot feeling office.											
4 Hamicide Could not be building, etc. (Specify) Annual House Number, setting, street, sectory, office City or Town, State)											
29a. CERTIFIER	IEAING BHAGIO	AN: To the heat of and	ourle de la	ath arm	and albeit and	to and it					
		AN: To the best of my kn On the basis of examins									end manner as stated.
		- Collection	77.00	- 0 - 0 - 0		т —					
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNEO (Month, Day, Year) November 28, 1994											
38 NAME AND ADDRESS OF	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
Dr. Martin		0				nter Driv	re. #	205 Gr	eenhe	elt.	MD 20770
31. DATE FILED (Month, Day,		32_REGISTRAR'S SI	GNATURE		<i>a</i>					,	
NOV 2 9	1 1994	Fretia David	3000-Mar	delle							- 1



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with an after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be missed that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

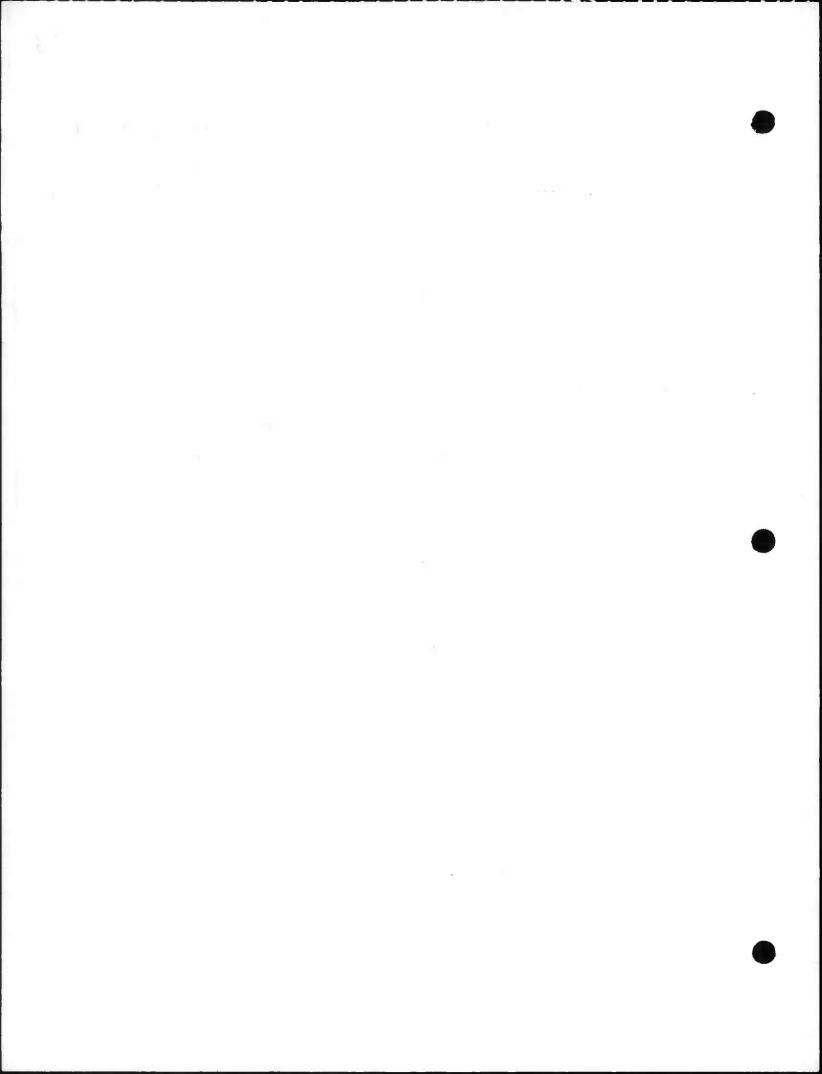
FOR STATE

	REGISTRAR		CI	:KIIIF	ICAI E	PE DEATH	RE	G. NO.		
	t. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH DAY	YEAR	3. TIME OF DEATH
	CHRISTOPHER	C			BAKE	R	NOV	25	74	1/58 A H
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1 YE		7. DATE OF BI (Month, Day,	RTH Year)	6. BIRTI	PLACE (State or Foreign
	579-03-7819	XXM2 F	83	YRS.	MONTHS DA	I HOURS WIN.	NOVEME		11	CAROLINA
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TO	VN OR LOCATION OF	DEATH	9c. CC	UNTY OF D	
OR	HOLY CROSS HOS	SPITAL			SIL	VER SPRI	NG	MOI	NTGO	MERY
ַ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				Y, TOWN OR LO					
<u> </u>							,			10d. INSIDE CITY LIMITS? 1 YES 4 NO
	N/A N/	Λ		WA	SHING	TON, D.				
RA	112 6462 1 945 100 122					101. ZIP CODE				WHAT COUNTRY?
FUNERAL DIRECTOR	4926 - 9th STRI					20011			J.S.	
	1 Never Married 2XXMarried	12. WAS DECEDENT FORCES? 1	YES X T	MED IO		DECENDENT OF HISP , specify Cuban, Maxi-			14. RAC	E — American Indian, k, Whita, atc.
ВҰ	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆	YESKO Spec	illy:		Spec	BLACK
ü	15. DECEDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL OCCUI	ATION	16b. KIND	OF BUSINESS/I	NDUSTRY	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	(G.	ive kind of a Do NOT us	vork done during	most of working				
7	5th	00.1000 (1.4.0.0)	′	С	HEF		F	RIVAT	Е	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S N	AME (First, Middle,	Maiden Surname)	
BE C	JAMES BAKER					SUSI	2			
	19a. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS (Str	eet and Number or Rura	l Route Number, Ci	ty or Town, State,	Zip Code)	
2	RUTH J. BAKER	(WIFE)		926	- 9t	h STREET	, N.W.	: WDC	20	011
	20a. METHOD OF DISPOSITION	and door Physic			OF DISPOSITION	(Name of	PATE	20c LOCATION	— City or To	own, State
	4 Donation 6 Other (Specify)	oval from State	FOR	matory or o	NCOLN	CEMETER		754 B	RENT	WOOD, MD.
	21. SIGNATURE OF PUNERAL SERVICE LIC	ENSEL	12		22. NAM	E AND ADDRESS OF I	ACILITY			
	theel 1	5 1	1/	•						HOME, INC
	23. PART /. Enter the diseases, or c	omplications the	caused the de	eth. Do r	1 / 1 b	MENNED)	Ch as cardiac	or menimeters	N . ;	WDC 20011
	' ahock, or heert failure. I	List only one ceu	se on each line	V				or respiratory (intout,	Intervei Between
- 4	iMMEDIATE CAUSE (Finel disease or condition	Volte	inila.	I	Ril	lation Acciden				Onset and Death
- 13	resulting in death)	DUE TO	OR AS A CONSE)	D. SVVVI	woun				MINUTES
- 1	_	Cosila	D/1 1/	15011	lan 1	receler	+			Cweeks
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		OR AS A CONSEC			,000,000	- V			ouecres .
PA	ceuse. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	j:					
E	resulting in death) LAST	1,								
	PART II. Other significent condition	a contributing to	death but not a	anultina.	n the under	ulee souss stries t	Diet I			
EDICAL	DIAR IT IN	ollit.	death but not t	esuiting	in the unger	ying ceuse given i	n Part I. 24a.	WAS AN AUTOPS PERFORMED?	Y 246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	1211136000 11	u u u u					t [YES 2 NO		COMPLETION OF CAUSE OF DEATH?
										t 🗌 YES 2 🗌 NO
AN	25. WAS CASE REFERRED TO MEDICAL		-							
PHYSICIAN: M	EXAMINER?	HOSPITAL:	TALL TO THE TO THE TALL THE		OTHER:	B. PLACE OF DEATH (C				
175	1 YES 2 P NO 27. MANNER OF DEATH	1 Inputiont 2 I			-	Home 5 Realdence				
	1º Natural 5 Pending	(Month, De		28b. TIM INJ	URY	INJURY AT WORK?	26d. DESCRIB	E HOW INJURY O	CCURED	
ΒY	2 Accident Investigation	28° DI ACE OI	E IN II I III W			YES 2 NO				
	3 Suicide 8 Could not be 4 Homicide determined	bullding,	FINJURY — At ho etc. (Specify)	me, iarm, i	irreet, ractory,	offica	City or Tow	(Street and Numl m, State)	per or Rural i	Route Number,
<u> </u>	29a. CERTIFIER			_						
AP.	(Check only									
COMPLETED	2 MEDICAL EXAMINE	R: On the basis of a	emination end/or i	nveatigatio	n, in my opinio	n, death occured at th	e time, data end p	place, and due to	the ceuse(a) and manner as stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER		10			29c. LICENSE N	JMBER	29d. D.	ATE SIGNED	(Month, Day, Year)
10	jaine	D/14	Ker	_/	NP	DZZ	836	-	You,	25, 94
	Control of the Contro	COMPLETED CAUS	E OF BEATH (ITE	1 27 (3ps.	Print)	-			,	
)		HAFFER	1011 1	V.CA	PHAL	SINE,	WAShir	UgVON	PC	20002
	31. DATE FILED NOW 2013/601 199	4 32. REGISTRA	R'S SIGNATURE	-Rand	all	DZZ ST NE				

1 - STATE REGISTRAR

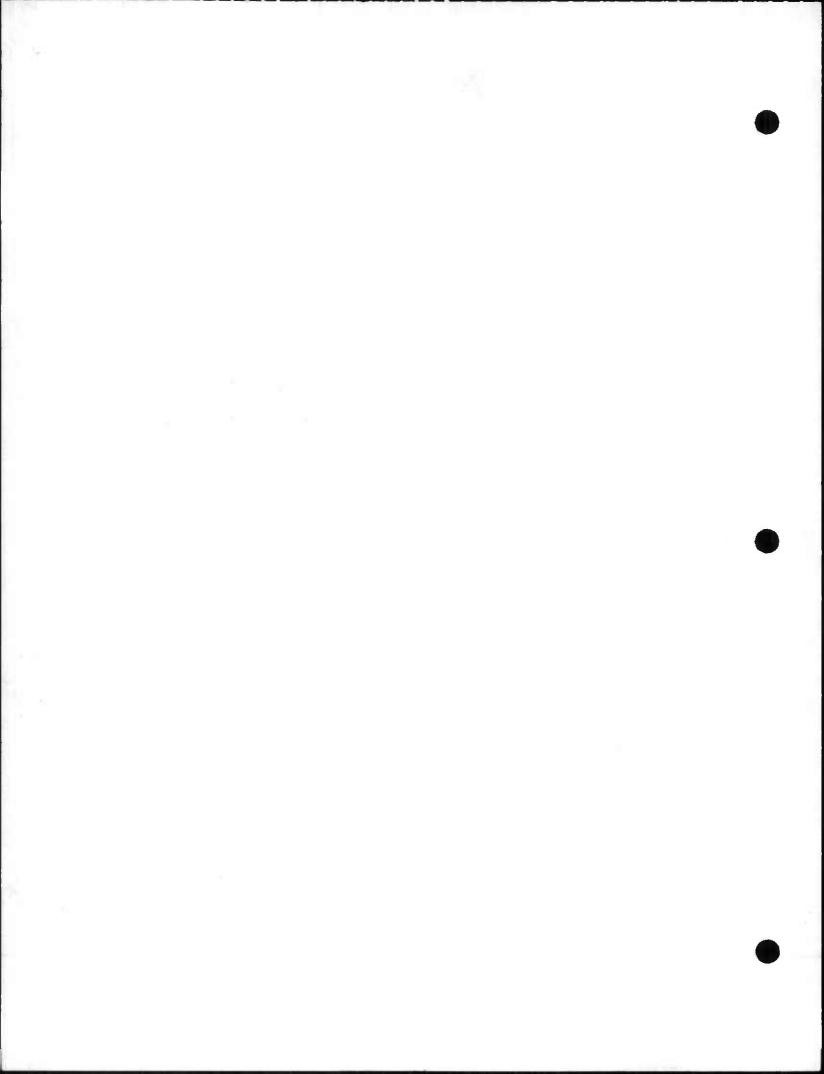
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						ULIT	THI TOAT		DLA	111		HEG. NO.			
		1. DECEDENT'S NAME (First,			-						2. DATE (OF DEATH DA	ν .		TIME OF DEATH
				t Regina	Bauma	in_					Nove	mber "	28, 1	994	5:25A M
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In	yrs. last birtl		R 1 YEAR	IF UNDE		7. DATE C	F BIRTH		8. BIRTHPL	ACE (State or Foreign
_		226-26-0862		1 □ M 2 🔀 F	9	0 Y	RS. MONTHS	DAYS	HOURS	MIN.		14. 1	904	Vashi	ngton, DC
3 should		9a. FACILITY NAME (# not in:	stitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCAT	ON OF DE		_ , ,		TY OF DEA	
	E E	Doctor's Con	mmunit	v Hospit	·a1		1.21	nham					Drine	o Co	orge's
1, 2,	15	RESIDENCE OF DEC	EDENT	7 1100710				main					TITHE	.e	orge s
sage.	DIRECTOR	10e. STATE	10b. COUNTY	1		10-	c. CITY, TOWN	OR LOCA	TION					10	Od. INSIDE CITY LIMITS?
ية ن	0	Maryland	Princ	e George	e's		College	Pan	rk					1	YES 2 NO
Pera	A	10e. STREET AND NUMBER							t. ZIP COD	E			10g. CITIZ	EN OF WH	AT COUNTRY?
nsit	E .	9900 Cherry	Hill	Road		20740				10			U.S.	Α.	
-0020 ling physician. the burial-transit permit. Pages 1,	FUNERAL	11. MARITAL STATUS		12. WAS DECEDER	NT EVER IN U	J.S. ARMED	13	WAS DEC	CENDENT (OF HISPAN	NIC ORIGIN?	(Specify Yes		14. RACE	- American Indian,
9 P	BY F	1 Never Married 2		IF YES, GIVE	CES? 1 ☐ YES 2 ☒ NO If yes, specify Cuban, Maxican; 1 YES 2 ☒ NO Specify: 1 ☐ YES 2 ☒ NO Specify:							icen, etc.)		Specify:	White, atc.
5-0020 anding physic as the burial		3 X Widowed 4 Divo													White
21 after			EDENT'S EDU		1	(Give kir	ENT'S USUAL O	during me		na	16b.	KIND OF BUS	INESS/INDU	STRY	
21 tal or for u	l iii	Elementary/Secondary (0	-12)	College (1-4 or 5		life. Do f	VOT use retired.			•					
N N N N N N N N N N N N N N N N N N N	₹ E	6				Cleri	<u>ical</u>				P	rivate	2.5		
YLAND 2121 by the hospital or ath be detached for use		17. FATHER'S NAME (First, Mi										iddle, Maiden			
AYL d by	111	William McC				W			(Ur	ıknow	vn) M	cCarth	ıy		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transfilled at more	2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
F, IV		Dallas W. Ba		Jr.		211	Sun Pa	ırk I	Lane,	Hun	nting	town,	Mary1	.and	20639
ORE 6 may ector, pa		20a, METHOD OF DISPOSITI 1 N Burial 2 Crematio		oval Irom State	20b. Pl	LACEANDE	DATE OF DISPO	SITION (No	ame of		DATE	20c. LO	CATION — C	ity or Town	, State
MO ge 6 irecto		4 Donation 5 Dother			For	t Li	ncoln	Ceme	tery	12.	/02/9	4 Brei	ntwoo	d, Ma	ryland
ALTIMORI death. Page 6 ma funeral director, p		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE					ND ADDRE			_			
BALTIMORE, I after death. Page 6 may be yo the funeral director, page moval.		Francis Gasch's Sons Funeral Home 4739 Baltimore Ave., Hyattsyille													
B rs after removal		23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final													MD 20781 Approximate
Hours after d in by th or remova															Interval Between
file file		IMMEDIATE CAUSE (Fin disease or condition	al		C	2-1	. à	4_							Onset and Death
3760, nted within cours completely filled in ial. cremation, or re		resulting in death)	7	e. DUE TO	(OR AS A C	SD11	LEM ICE OF):	α							7 VAVO
SOX 68760, are be executed within any spician and completely fille prior to burial, cremation.			_	D-	cent	_	Ch-)	00	ato	. Am	`~a. /				100 10
P.O. BOX 68' h certificate be execute anding physician and c Hygiene prior to buria	CERTIFICATION	Sequentisity list condition if any, leading to immediate			(OR AS A C		ICE OF):	204	ste	au	1717				1 1 Canta
t, P.O. BOX leath certificate be e attending physician mtal Hygiene prior to	ΑŢ	cause. Enter UNDERLYI	NG	T	Diab	aton	m	011	ihos						
certificate ding physical hygiene pri	Ĕ	CAUSE (Disease or injust that initiated events	ν]		(OR AS A C		CE OF):		100						1
O.O. I cert	E	resulting in death) LAST	r l	. I)e~~	enh									
ORDS, s that the dear ned by the att ith and Menta	A	PART ii. Other significer	nt condition	s contributing to	deeth but	not result	ting in the u	nderiyin	g ceuse	given in	Part I.	24a. WAS AN			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
	EDICAL											1 YES 2		CC	OMPLETION OF CAUSE F DEATH?
PEC(requires peen signe of Health											_				YES 2 NO
	Z	DID TOBACCO US	SE CONTI	RIBUTE TO CA	USE OF	DEATH	YES	NO [JUNC	ERTAIN	V 🗆				
Q 2 - 6	S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF	DEATH (Check								
NAME OF SECOND S		1 TES 2 NO		1 Inpatiant 2	ER/Outpatie	ant 3 🗆 D	OA 4 Nu		e 5 □ Re	aldenca	6 🗆 Other	(Specify)			
OF VI PHYSICIAN this certifical with the St	H	27. MANNER OF DEATH		26a. DATE OF (Month, D		286	. TIME OF	28c, JNJ WO	URY AT		28d. DE\$0	RIBE HOW IN	JURY OCCU	RED	
ON O DING PHYS After this death with	BY		Pending nveatigation	1000000			M		YES 2	NO					
ATTENDING ECTOR, Attan 8, after death	0	3 Suicide 6 0	erm, street, lac	tory, offic				TION (Street a	nd Number o	r Aural Aoul	te Number,				
DIVISION OF OR ATTENDING PHYSIC DIRECTOR: Ahm this car bours after death with th		4 Homicide	determined	A STATE A S	atc. (Specify)						Only or	rown, Sieley			
	12	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowled	lge, death o	ccurred at the	time, data	and place	, end due	to the caus	e(a) and man	nor as states	1.	
HOSPITAL FUNERAL WITHIN 72															nd manner as stated.
FUNE WITHIN	0	29b. SIGNATURE AND TITLE		- 1		1				ENSE NUM					
TO THE HOSPI TO THE FLINEP OF Fled within	BE			4101	ind	209	Sil	a Ll	200. 270	D		0	DATE:	- 7 (onth, Day, Year)
228	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEATH	H (ITEM 27)	(Type, Print)		0.	0 9	700	, ,		20	r- 4.4
(4)		D. GIN	VG 4	MOM	306	0	MI	1	,UD,	1.18.	Ra	1 1	3	in M	y Danil
1/		31. DATE FILED (Manin, Day, P	Par/1004	32. REGISTRA	ARAS SIGNATI	URE M	1.00	CNE		14	y vo	1	لسمار	161	· 1201 A
		พบง 3 ใ	1334	32. REGISTRA	Davidos	m-Man	Men								



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT; it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTAL HYGIEN	_		
1	1. DECEDENT'S NAME (First, Middle, Last)	(Fay Yvonne	Butler)			2. DATE OF DEATH			. TIME OF DEATH
	Lay,	Butler						EAR	1720 "
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6.	BIRTHPL Country)	ACE (State or Foreign
3	075-44-6491	1 □ M 2 🖾 F 55	YRS.					Jama	
œ	9a. FACILITY NAME (If not institution, give				OR LOCATION OF DI	EATH	9c. COUNTY		
5	Washington Advent	.ist nospital		Takoma	Park		Montg	gomen	су
REC	10a. STATE 10b. COUNT	•	10c, CITY	TOWN OR LOCA	TION			10	Dd. INSIDE CITY LIMITS?
D		e George's	Ну	attsvil	1e			1,	YES 2 NO
RAI	10e. STREET AND NUMBER	1 //101		10	ZIP CODE				AT COUNTRY?
FUNERAL DIRECTOR	2117 Guilford Roa	12. WAS DECEDENT EVER II	NII S ADMED	I 40 MM 0 DEC	20783	NIC ORIGIN? (Specify Yes	U.S.		
	1 🔀 Never Married 2 🗌 Married	FORCES? 1 YES	2 X NO	If yes, sp		n, Puerto Rican, etc.)	14 or No —	Black, V	- American Indien, Vhife, atc.
ВУ	3 Widowed 4 Divorced	" TEO, GIVE WAN ON D		1 128	Z LA NO Specif	у.	- 1	Specify:	Black
TED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S U	ork done during me	ON ist of working	16b. KIND OF BU	SINESS/INDUS	TRY	
) LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	iife. Do NOT use	0.000		Frains	anina	C	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Data Ent	. L y	18 MOTHED'S NA	Engine		Comp	Dany
Ö	Frederick T. Bu	ıtler			Agatha		larke		
TO BE	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or Tow		ode) 98	3438-1134
۲	Gregory S. Watt		735 5t	h Stree	t, P.O.	Box 2091,	McChor	d AF	B, WA
	20a METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Ran	noval from State cer	netery, crematory or oth	F DISPOSITION (Na	me of	DATE 20c. LO	CATION — CIT	y or Town	, State
	4 Donetion 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		ashington			12/2/94 Su	itland	, Ma	ryland
	Ol. O	1000			is Gasch	's Sons Fu	neral	Home	, P.A.
	Malles	T. Bell	Y	4739	Baltimor	e Ave.,Hya	ttsvil	1e,	MD 20781
	23. PART i. Enter the dieeeses, Dr shock, Dr heart fallure.	List only one cause on e	d the death. Do no each line.	ot enter the mo	de of dying, suc	h aa cerdiec Dr reep	iretory arree	t,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition	. DNTRA	CDANI	2 2			Onaet and Death		
	resulting in death)		CONSEQUENCE OF		DCC	ENINU			
z	Security of the security	b							
E	Sequentially liet conditions, if any, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	:					
FIC	CAUSE (Disease or injury that initieted evente	cDUE TO (OR AS /	CONSEQUENCE OF						
CERTIFICATION	reaulting in death) LAST	4							
	PART II. Other aignificent condition	no enatributing to death b		ACC					
MEDICAL	PART II. Other agrimonic obligation	e contributing to deeth b	out not resulting in	the underlyin	g ceuee given in	Part i. 24a. WAS AN PERFOR		AV	AILABLE PRIOR TO
EDI						- 1 VES 2	□ NO	OF	DMPLETION OF CAUSE F DEATH?
Ξ.	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	DE DEATH YES	S CI NO E	UNCERTAIL			1 1	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH		ONCERIAII	<u> </u>			
SIC	1 YES 2 NO	HOSPITAL:		OTHER: 4 - Nursing Hom	e 5 🗆 Raaldenca	6 ☐ Other (Specify)			
FH	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		URY AT	28d. DESCRIBE HOW I	NJURY OCCUP	RED	
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 '	res 2 🗌 NO				
ED	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, etc. (Spec	— At home, farm, st cify)	reet, factory, offic		28f. LOCATION (Street a City or Town, State)	and Number or	Rural Rout	te Number,
E I	29a. CERTIFIER								
COMPLET	(Check only The CEHTIFTING PHYS	ER: On the best of my know						augu(a) aug	
	29b. S/GNATURE AND TITLE OF CERTIFIE			, in my opinion, o					
BE	1 2 2 2				D 19	9.71	PAG. DATE S	2 9	onth, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, I	Print)	(1))	Δ Λ	1000		117
İ	K 200 ALKAR	7610 CAT	ROLL	GKE.	H230 7	Akomp	ן א ויוץ	Cin	20915
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN							



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MARYLAND 21215-002	
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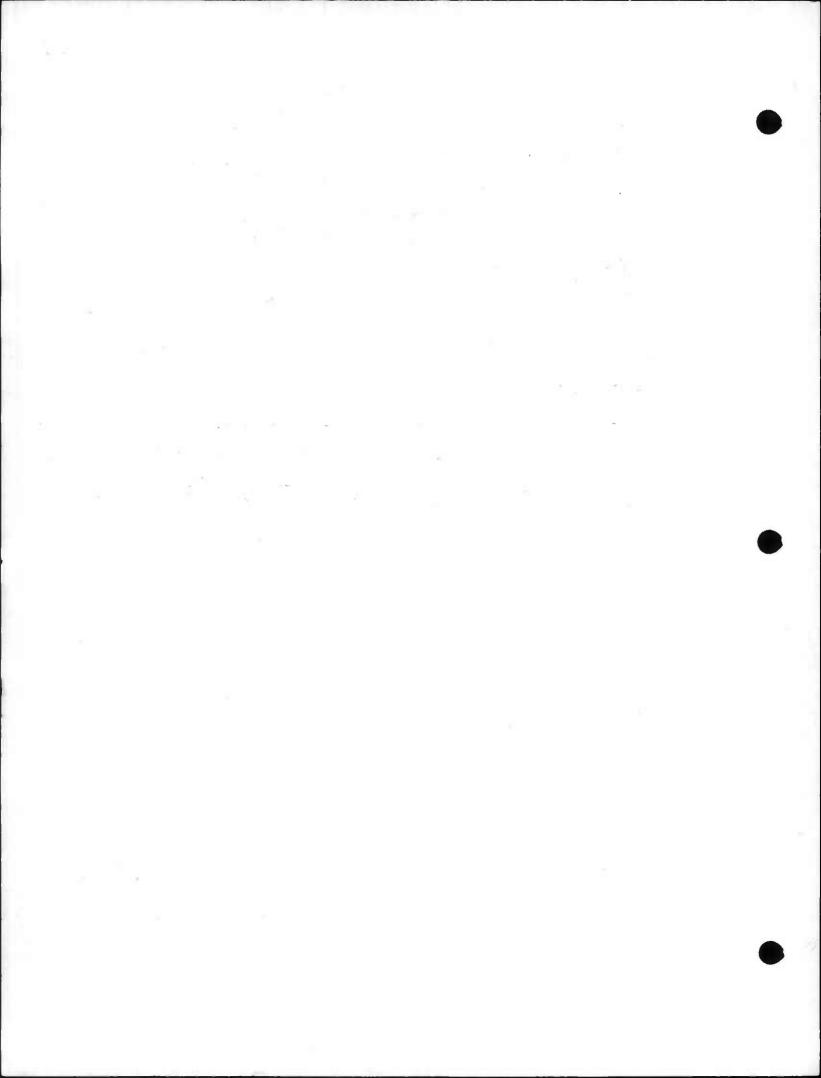
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FINEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 burial with and Mental hygines point to burial hygines prior to burial any pages, por removal.

MEMORFARM' I than 28 its marked or than 28 shows any listing no other traumatile event the marked assumes must be marked as name.

	1 - FOR STATE OF MARYLAN REGISTRAR	D / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
Ť	1. DECEDENT'S NAME (First, Migdle, Last) RELUIN BIEG	9		EAR 3. TIME OF DEATH
		s. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	NOULTHBER 27 - 199 7. DATE OF BIRTH 6.	BIRTHPLACE (State or Foreign
	577.88.8488 18m20 = 3c	YRS. MONTHS DAYS HOURS MIN.		WASHINGTON D
OR	SOUTHERN MARY/AND A	SPITAL CHY, TOWN OR LOCATION OF D		NCK- OKONGER
DIRECTOR	10a. STATE 10b. COUNTY	10c, CITY, TOWN OR LOCATION		10d, INSIDE CITY LIMITS?
	N/A N/A	WASHINGTON, D.C		1 XYES 2 NO
FUNERAL	1423 HOLBROOK ST. N.E.	10f. ZIP CODE 20002		ED STATES
J.	11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S.		NIC ORIGIN? (Specify Yee or No- 14	RACE — American Indian, Black, White, etc.
ВУ	1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 3 Wildowed 4 Divorced	1 TYES XX XNO Speci		BLACK
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	n. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSINESS/INDUS	
COMPLETED	Elementery/Secondery (0-12) College (1-4 or 5 +)	ilie. Do NOT use retired.)	N/A	
OMI	17. FATHER'S NAME (First, Middle, Last)		AME (First, Middle, Melden Sumame)	
BEC	MELVIN BIGGS	VIRGI		
5	190. INFORMANT'S NAME (Type/Print) CRYSTAL A. BIGGS	1948 RANDOLPH ST.	N.W., WASHINGT	
	200 METHOD OF DISPOSITION 20b. PL	ACE AND DATE OF DISPOSITION (Name of	DATE 20c LOCATION — City	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE LICENSEE			TON. D.C.
	A TOO I I I	22. NAME AND ADDRESS OF F. E. M. DUDLEY	FUNERAL HOME SLAND AVE., MT	
	23. PART I. Erner the diseases, or complications that caused the	3200 RHODE I	SLAND AVE., MT	RAINIER, MD
7	shock, or heert failure. List only one cause on each	line.		Interval Between Onset and Death
	disease or condition e.	eral Rellinos	ua	
	DUE TO (OR AS A CO	NSEQUENCE OF:		
TIO	Sequentially list conditions, if sny, leading to immediate	NSEQUENCE OF):		
FICA	cause. Enter UNDERLYING CAUSE (Dissess or Injury that initiated water) DUE TO (OR AS A CO	NSFOLIENCE OF		
CERTIFICATION	thet initiated events resulting in death) LAST	notestine or j.		
AL CE	PART ii. Other significent conditions contributing to deeth but r	not resulting in the underlying cause given in	Part i. 24a, WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
OICA			PERFORMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE
MEDIC				OF DEATH?
AN	DID TOBACCO USE CONTRIBUTE TO CA	AUSE OF DEATH YES NO		
PHYSICIAN:	EXAMINERS 1 VES 2 NO HOSPITAL: 1 Vinpetient 2 ER/Outpetle	OTHER:	19 22 21	
PH	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCUP	RED
B	2 Accident Investigation	M 1 YES 2 NO	26f. LOCATION (Street end Number or	Dural Doubs Mumbar
ETED	4 Homicide detarmined building, etc. (Specify)	Total and the second se	City or Town, State)	nurei Noute Number,
PLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge	e, death occurred at the time, date end place, end du	e to the cause(e) end manner es stated.	
COMPL	one) 2 MEDICAL EXAMINER: On the basis of examination en	d/or investigation, in my opinion, death occured at the	time, date end place, end due to the c	ause(e) end manner ee stated.
H	296 SIGNATURE AND TITLE OF CENTIFIER	A 29c. MCENSE NU	MBER 29d. DATE S	IGNED (Month, Pey, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print)	0	2012
	LAXMI SERWA - 7700	OLD BLANCT The	nu Clinto	n Monyland
1 1	31. DATE FILED (Month, Day, Year) IF () 9 1994 June Day doon - North	352		



permit. Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

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will

3NPATE FILED (Month) Pay Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

for les

, 32. REGISTRAR'S SIGNATURE

ia Davidson-Mandell

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NICOLE WAYNETTE **BOWMAN** NOV. 23 1994 12:06 AM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birtnday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 3-26-76 DAYS HOURS 1 M 2 X F YRS. **2**12–17–8263 18 Wash., D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MALCOLN GROW MEDICAL CENTER CLINTON MONTGOMERY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. Prince Georges Oxon Hill 1X YES 2 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 132- N. Huron Drive 20745 U.S.A. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 X Never Married 2 Married 3 Widowed 4 Divorced Black 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Waitress n/a 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Marcella Long Wayne Bowman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella Kelton 132- N. Huron Drive, Oxon Hill, Md. 20745 20s. METHOD OF DISPOSITION

1A Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 11/28 Suitland, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hackett's Funeral Chapel, Inc. W. Hackit 814- Upshur Street, N.W. 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, Approximate ahock, or haart failura. List only ona causa on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Injuries rultiple resulting in death) DUE TO (OR AS A CONSEQUENCE OF Sequantially list conditions, DUE TO (DR AS A CONSEDUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 VES 2 NO OF DEATH? TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO otin Uncertain otin25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA XXYES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY 26d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT 1 Natural 5 Pending Investigation Pedestrian -22-94 1102 PM Struck Si 2 Accident 28a. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etog(Specify) 281. LOCATION (Street and Number or Rural Route Number of Rural Ro 3 Sulcide 6 Could not be 4 Homicide Roadwar 29s. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) end manner as stated. 2- MEDICAL EXAMINER: On the beele of ext imination end/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) O.C.M.E. NOV.23,1994

111 Penn Street, Baltimore, Maryland 21201

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3-7 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

INPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) ALPHONSO J. BROADITURST JR NOVER DAY 12:25									
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 X M 2 F 60 4. SOCIAL SECURITY NUMBER 24 HRS. 1 YRS. 6. AGE (In yrs. last birthday) 1 YRS. 7. DATE OF BIRTH (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs. last birthday) 1 YRS. 8. BIRTHHAM (In yrs									
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH P. G. RESIDENCE OF DECEDENT									
JEC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?									
	MARYLAND PRINCE GEORGE SEAT PLEASANT 1X) YES 2 \(\text{NO} \)									
FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 1125 CARRINGTON AVENUE 20743 U. S. A.									
B	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed FORCES? 1 X Yes 2 No If yes, specify Cuban, Mexican, Puarlo Rican, etc.) 13. Was Decendent of Hispanic Origin? (Specify Yea or No Black, Whita, atc.) 14. RACE — American Indian, Black, Whita, atc. 15. Was Decembent of Hispanic Origin? (Specify Yea or No Black, Whita, atc.) 16. Was Decembent of Hispanic Origin? (Specify Yea or No Black, Whita, atc.) 17. Was Decembent of Hispanic Origin? (Specify Yea or No Black, Whita, atc.) 18. Was Decembent of Hispanic Origin? (Specify Yea or No Black, Whita, atc.) 19. Was Decembent of Hispanic Origin? (Specify Yea or No Black, Whita, atc.)									
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working									
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∑ O	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)									
BE	WILEY BROADHURST ELIZABETH NICKENS									
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	ANDREA V. BROARDHURST 236 RANDOLPH PL., N. E. WASH., D. C. 20002 20a. METHOD OF DISPOSITION DATE 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City of Town, State									
	1X Burlel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Cemetery, cremetory, or other place) HARMONY MEMORIAL PARK 11/30 LANDOVER, MD									
	21. SIGNATURE OF EUNERAL SERVICE LICENSEE PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH S.T, N. E. WASH., D. C. 20002									
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST Onset and Death Onset and Death Onset and Death Onset and Death DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
DICAL	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24e. WAS AN AUTOPSY PERFORMED? PERFORMED? 1 VES 2 NO 0F DEATH?									
N: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
3	25. WAS CASE REFEBRED TO MEDICAL EXAMINED: OTHER:									
PHYSICIAN:	1 TES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 8 Other (Specify)									
BY P	28a. DATE OF INJURY 1 Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO									
ED	2 Suicide 8 Could not be determined City or Town, State) 286. PLACE OF INJURY — All home, farm, atreet, factory, office City or Town, State) 287. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(a) and manner ea stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER Alfmandial Month, Day, Year) 128. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 128. PGF									
	30. NAME AND ADDRESS OFFERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALLENDO (ALLEND). 1070, TRAFTONDR, LARGO ND 20772									
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE And See									

Julia Broun

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

		REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO.	,				
		1. OECEDENT'S NAME (First, Middle, Last)	7	BROW) N		2. DATE OF DEATH MONTH DO NOUR TO SELECT	19- /94K	3. TIME OF DEATH A			
		4. SOCIAL SECURITY NUMBER 579-32-4990	5. SEX 6. AGE	(In yrs. last birthday)	F UNDER † YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) September 5,	6 BIRT	THPLACE (State or Foreign only) Yland			
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permit. Pages		D.C.		Was	shington				1 XXYES 2 NO			
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by the hos be detach at once.		17. FATHER'S NAME (First, Middle, Last) GEONGE BY	0. n			18. MOTHER'S NA	ME (First, Middle, Meiden	Surneme)				
retained b 5 should t	BE	19s. INFORMANT'S NAME (Type/Print)	OWIT	19b. MAILING AD	DRESS (Street a	and Number or Rural	Susie WIlls Route Number, City or Tow.	n, State, Zio Code)				
5 5	유	Mary Jackson (Niece)					Head, Maryla					
6 may ctor, pa		20e. METHOD OF DISPOSITION *** Burlel 2	oval from State 20th	PLACE AND DATE OF Contestery, crematory or other	e AND DATE OF CISPOSITION (Name of remailtory or other place) Name of the place of							
		21. SIGNATURE OF FUNERAL SERVICE LIC			22, NAME AN	ins Funera		WIGOVET 5 I	iai y rana			
ther death. the funer oval. al exam	_	Anet	· mae	esar	4339	Hunt Place	e, N.E. Wash	hington, D	.C. 20019			
in 24 hours after ely filled in by the nation, or removal , the medical		23. PAPM. Entar the diseases, or abock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cause List only one cause on e	d the death. Do not each line.	antar the mo	Oras	haa cardiac or reapi	ratory arreat,	Approximata interval Between Onset and Death			
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v rec		DID TOBACCO USE		CAUSE OF D	DEATH Y	ES NO			1 YES 2 NO			
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch						
SICIAN: The certificate the State	14S	1 VES 2 NO 27. MANNER OF DEATH	165 Inpatient 2 ☐ ER/Outs		☐ Nursing Hom		8 Other (Specify) 26d. DE\$CRIBE HOW II	N II IBY OCCUPED				
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보 보 전 등	COMPLET	10.100.1101.11	CIAN: To the best of my know R: On the beele of examination						(e) and manner se stated,			
TO THE HOSPIT TO THE FUNER De filed within 7 IMPORTANT:	BE 0	296. SIGNATURE AND TITLE OF CERTIFIED	209	200 mel	13	29c. LICENSE NUI	MBER 7L1	29d. DATE SIGNE	O (Month, Day, Year)			
223	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	int)	117	4/1	//	90725			
		ESSAM TE				NOR AM	enue CL	inton 1	Menyland			
		NOV 2 8 1994	32. REDISTRAR'S SIGN	Son-Randall								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

_											HEG. NO.			
1	1. DECEDENT'S NAME (First, I	Middle, Last)								2. DATE C	DA		YEAR	3. TIME OF DEATH
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	4. SOCIAL SECURITY NUMBE	R	5. SEX		. last birthday)	IF UNDER	DAYS	HOURS	R 24 HRS.	7. DATE O (Month,	Day, Year)		Country)	
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2	Doctors' Con		y Hospit	al		Lai	nham					Pri	nce G	eorge's
2		tob. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY
DIRECTOR	Maryland	Princ	e George	e's	Bot	wie								LIMITS?
A	10e. STREET AND NUMBER				10f. ZIP CODE					10g. CITIZEN OF WHAT				
ER	12418 Shaw	mont I	ane					20	715		United S			States
FUNERAL	11. MARITAL STATUS	22.8.22	12. WAS DECEDEN FORCES? 1	T EVER IN U.S.	. ARMED					NIC ORIGIN?		or No —	14. RACE -	- American Indian, White, etc.
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ŭ	17. FATHER'S NAME (First, Middle, Lest) Samuel Ballentine 18. MOTHER'S NAME (First, Middle, Melden Surneme) Mary McGovern													
BE	10. INFORMANTIC NAME (Tradition)													
2	Patricia Do	lan								Bowie				716
	200. METHOD OF DISPOSITIO		_	20b. PLA	CE AND DATE	OF DISPOS	ITION (Na	me of		DATE	20c. LO	CATION -	City or Town	n, State
	t ∰ Burlai 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S		oval from State	_ cametery	red H	ther place)	Chu	rch (Ceme	tery	Bot	wie 1	Maryl:	and
	21. SIGNATURE OF FUNERAL					22.	NAME AP	ND ADDRE	SS OF FA	CILITY				
	Robert E. Evans, Pres. Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 207													
	23. PART I. Enter the dis-					not antar	the mo	Ann.	apol	1S Kd	BOW	ie M	d. 20	/15 Approximata
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	resulting in death)			(OR AS A CON				1 00	m L					4 hour
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PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?				LACE OF DEA									
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BY	1 Netural 5 Pe	ending vestigation			М	1 🗆 1] NO						
ED	3 Sulcide 8 Co	ould not be	28a. PLACE O building,	F INJURY — At	t home, ferm,	street, tact	ory, office	•		281. LOCAT	ION (Street e Town, State)	nd Numbe	r or Rumi Ros	ute Number,
	4 Homicide de													
2	29a. CERTIFIER (Check only	YING PHYSIC	CIAN: To the best of	my knowledge	, death occurr	ed at the t	lme, date	and placa	, and dua	to the cause	(e) and man	ner aa ata	ted.	
COMPLET	one) 2 MEDIC	AL EXAMINER	R: On the basis of s	ramination and	or investigation	n, in my c	pinion, d	eath occur	red at the	time, date e	nd place, en	d dua to t	he cause(e) e	end manner ee stated.
w	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)													
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유	30. NAME AND ADDRESS OF F				TEM 27) (Type	Print)	· · · ·			797.3	-	_		
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	31. DATE FILED Month, Pay 16	9 1994	32. REGISTRA	R'S SIGNATUR	n-Rand	202								
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	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or
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r requires that the deam certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	O to manufact as from 22 shours and laters as other deminated accorded the modifical according to making a second
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IMPORTANT: If Item

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NOV. 27, ADALINE ANNETTE PIPES BEARD 1994 10:00 P. 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 1 - M 2 XXF 410-58-2571 OCT. 15. TENNESSEE 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2305 DAWSON STREET TEMPLE HILLS PRINCE GEORGE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND PRINCE GEORGE TEMPLE HILLS 1X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 2305 DAWSON STREET 20748 S. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 X Married 1 TES 2 NO Specify: 3 Widowed 4 Divorced BLACK 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi Elementary/Secondary (0-12) College (1-4 or 5+) YRS CIVIL RIGHTS INVESTIGATOR S. GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) DARRINGTON PIPES LAURA **YANCEY** 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) JESSE E. BEARD 2305 DAWSON STREET TEMPLE HILLS. MD 20748 20a. METHOD OF DISPOSITION
1X Burlal 2 ☐ Cremation 3 ☐ Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE RESURRECTION CEMETERY 12/1 4 Donation 5 Other (Specify) CLINTON, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE PINCKNEY-SPANGLER FUNERAL HOME plodore 8TH ST., N. E. WASH. D. C. 20002 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate shock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ ARCHOMS resulting in death) Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 - YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:

1 - YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA ng Home 5 📉 Residence 8 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending investiga 1 YES 2 NO 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify)

29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the lime, data and place, and due to line cause(a) and manner as steted.

2 _ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

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290. BAGNATUBE AND TITLE OF CERTIFIER	29C- LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

And the same of the same of the same of				11/00/
30, NAME AND ADDRES	OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)	(Tune Print) .	da.	
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31. DATE FILED (Month, Day, Year) 1994 32. REGISTRAR'S SIGNATURE Handrill

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28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

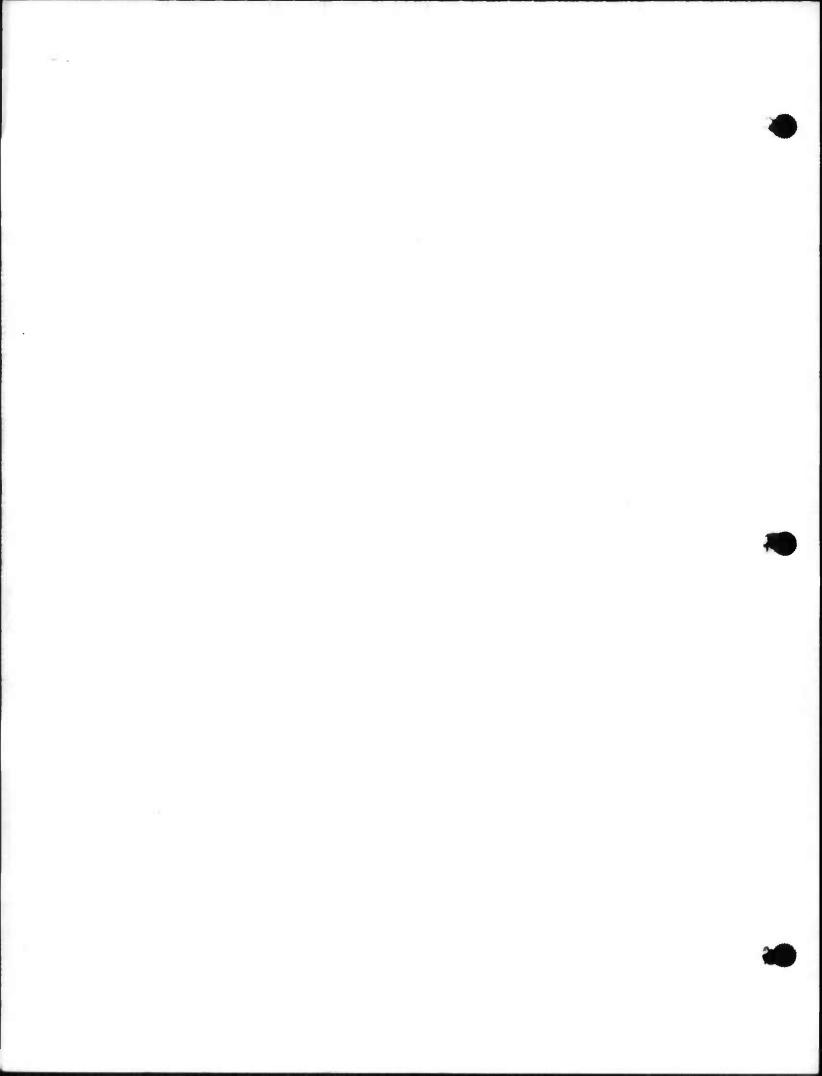
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Jes 1,	E E	10e. STATE	10b. COUNTY	1			10c. CITY,	TOWN O	R LOCAT	TION						10d. INSIDE CITY	,
~. 20	DIR	Maryland	Montg	omerv			Gait	hers	bur	g						1 XYES 2	NO
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niled in by the funeral director, page 5 should be detached for use on, or removal. The medical examiner must be notified at once.		· alex	1.80	uh		M	859					POPE F				, MD, 20	7/7
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or remove				List only one ca	use on e	ach line	le .			10						interval B	etween
the		iMMEDIATE CAUSE (Fi	naí	(P)	0.1	20	no fo	1/8	-	The	20	lees		6,10	500	CIRA	
ompletery at, crema event,		resulting in death)		DUE TO	OR AS	CONSE	DUENCE OF	:	cec	xee		- Ces	9 2	CAG.		yes	ENK.
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	B₹	1 Netural 6 Pending 2 Accident Investigation M 1 YES 2 NO															
4 D 00		3 Suicide 6 Could not be 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
DIRECTOR: After hours after death item 28 is ma	ETE	4 Homicide	determined												-7		
DIRE hours		29e. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best o	of my know	rledge, de	ath occurre	d at the ti	me, date	end place	, end due	to the cause(e) end mai	nner ee ata	ted.		
FUNERAL within 72 t	OMP		NCAL EXAMINE	R: On the basis of	magazini.	n end/or	Investigation	, in my o	pinion, (death occur	red at the	time, data en	d place, er	d due to th	he ceuse(e) end menner es i	atated.
THE FUNER filed within PORTANT:	00	296. SIGNATURE AND TITU	E_DF CENTIFIE	8 /	+					29c. LICI	ENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)	
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2 8 2	2	30. NAME AND ADDRESS O	F PERSON WI	IO COMPLETED CAL	JSE OF DE	EATH (ITE	M 27) (Type,	Print)		1 ""					1	, ,	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



1 - FOR STATE REGISTRAR

REG NO

AMENDED #9a, & 10e, 11/29/94, CYW, P.G. COUNTY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH REGINALD LEE BROWN NOV. 22 94 10:13 Am 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 10/19/1949 240-82-3586 XXM 2 | F DAYS HOURS 45 YRS North Carolina Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution laws are a figure 10305 CHANTACUA A 9C. COUNTY OF DEATH
PRINCE GEORGES 9b. CITY, TOWN OR LOCATION OF DEATH AVENUE LANHAM DIRECTOR RESIDENCE OF DECEDENT 10c CITY TOWN DR LOCATION 10# STATE 10b COUNTY 10d. INSIDE CITY MAryland Prince Georges' Lanham 1 K YES 2 ND permit. 100. STREET AND NUMBER TAUQUA 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10305 Chautuaguz Avenue USA Page 6 may be retained by the hospital or attending physician. It director, page 5 should be detached for use as the burial-transit 20706 FUNE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 ND Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NDT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 2YRS. PVT. CONSTRUCTION 17. FATHER'S NAME (First, Middle, Last) 18 MOTHER'S NAME (First Middle Meiden Surname notified at WILLIE H. BROWN HAZEL M. PICKARD BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3216 POPE ST. SE WASHINGTON, DC 20020 HAZEL M. BROWN/MOTHER pe 20a. METHOD OF DISPOSITION
1 □ Burlal 2 □ Cremation 3 ◯XRamoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director, CHURCH CEMETERY 4 Donation 5 Other (Specify) 11-30RUFFIN, NORTH CAROLINA medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY S FUNERAL HOME hours after death. 7474 LANDOVER ROAD LANDOVER, MD20785 filled in by the fion. or removal. the 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Final** the disease or condition Cardiac Tan porvoice completely resulting in death) other traumatic event, executed with DUE TO (DR AS A CONSEQUENCE OF burial. RUPTURED AORTA CERTIFICATION and Sequentially list conditions, HYPERTENSIVE 2 if any, leading to immediate cause. Enter UNDERLYING physician prior PKNOBSUOP12 CAUSE (Disease or Injury e attending physental Hygiene p DUE TO (OR AS A CONSEQUENCE OF P.O. that initiated events resulting in death) LAST 6 signed by the atter Health and Mental Injury, DIVISION OF VITAL RECORDS, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 | NO TES 2 | NO Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗗 PHYSICIAN: OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATH (Check only one) Item certificate h HOSPITAL: OTHER: 1 XXES 2 - NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5X Xesidence 6 ☐ Other (Specify) the 9 27. MANNER OF DEATH 26a. DATE OF INJURY 28c. INJURY AT this c 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation BY After 1 death 2 Acctdent 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 99 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number City or Town, State) DIRECTOR: / 6 Could not be COMPLETED 28 4 Homicide item 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. THE HOSPITAL OF THE FUNERAL DEFINED THE FUNERAL DEFINED THE FUNERAL DEFINED THE FORTANT: If its MEDICAL EXAMINER: On the basis of ax ation and/or investigation, in my opinion, death occured at the time, date end placa, and due to the ceuse(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BE O.C.M.E ▶ NOV. 23,1994 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1 wid (who-111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S ATGNATURE Mandrell

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death. Page 6 may be retained by the hospital or attending physician.

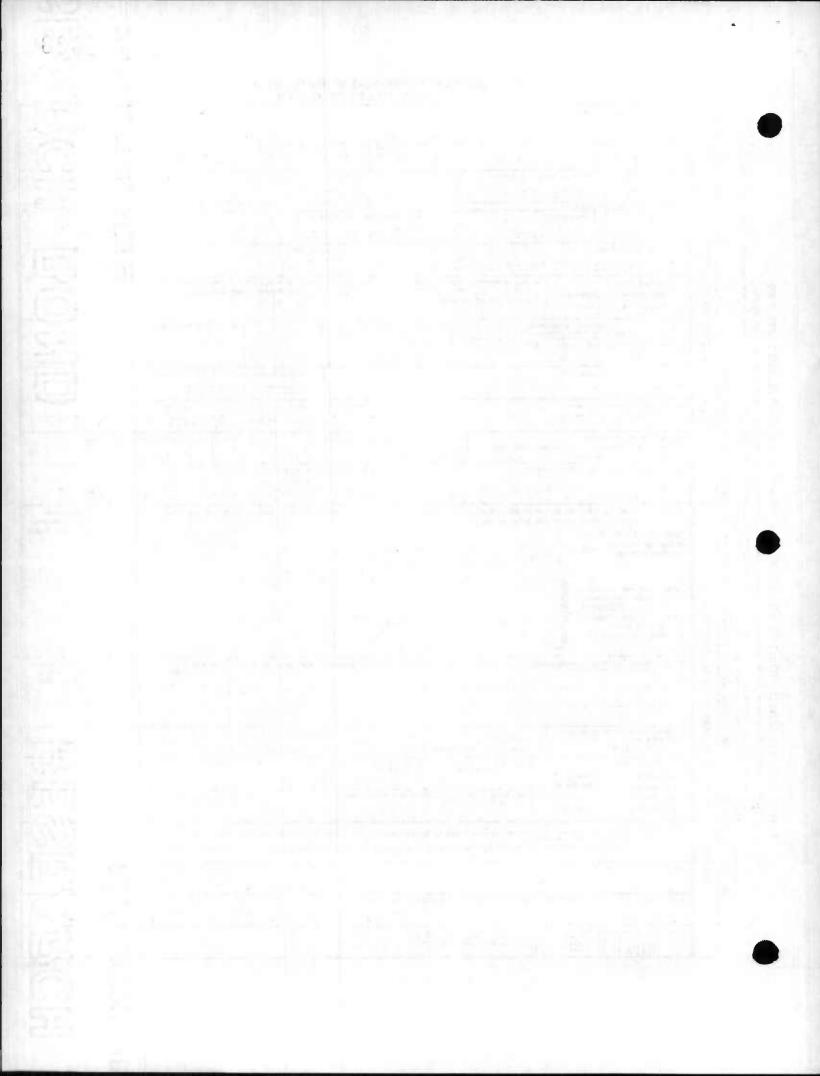
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO	O.	
1. DECEDENT'S NAME (First, Middle, I MARGARET MARY I					2. DATE OF DEATH MONTH NOV. 22,	1994	3. TIME OF DEATH 9:50 D
4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	I				
220-24-7004	1 M 2 M F	64 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTH (Month, Day, Year) Oct. 10,	1930	BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution,	give street and number)		9b. CITY, TOWN	OR LOCATION OF D			Y OF DEATH
Meridian Nurs	ing Home		Catons	ville		Ва	ltimore
RESIDENCE OF DECEDEN	т						
10a. STATE 10b. CC	UNTY		Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?
	Howard	E11	licott C	ity			1 TES 2 NO
10e. STREET AND NUMBER			10	. ZIP CODE		_	N OF WHAT COUNTRY?
8113 Forest Hi	ll Drive			21043		U.	S.A.
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 XNO	If yes, sp		NIC ORIGIN? (Specify Wan, Puerto Rican, etc.)	en or No — 14	A. RACE — American Indian, Black, Whita, etc. Specify: White
15. DECEDENT'S	FOURTION	I					
(Specify only highest	grade completed)	(Give kind of	WOUND OCCUPATI Work done during me se retired.)	on ost of working	16b. KIND OF BI	USINESS/INDUS	STRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Housev			M 172		
		nousev	VIIE				
17. FATHER'S NAME (First, Middle, Las	0				ME (First, Middle, Maide		
Louis Huber					ude Fisher		
19a. INFORMANT'S NAME (Type/Print) Edward J. Brus	sh				Route Number, City or To		ode) cy,Md. 21043
20a. METHOD OF DISPOSITION							
1 🗆 Burial 2 💢 Cremation 3 🗆	Removal from State c	0b. PLACE AND DATE emetery, crematory or o	ther place)				ty or Town, State
4 ☐ Donation 6 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	B	altimore			11-23-94		el, MD
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE 1 1 -T	1	HARRY	H. WITZ	KE FUNERAL	HOME	
yang,	A Wels	no	4112	Old Colu	mbia Pike	Ellico	tt City 2104
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	bDer	Mentia of	Alzhein	ers Dise	ease		
that initiated events resulting in death) LAST	d.	A CONSEQUENCE O	F):				
PART II. Other aignificent cond	itiona contributing to desth	but not resulting	in the underlyin	g ceuse given in	Part I. 24s. WAS A		24b. WERE AUTOPSY FINDING
					PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 TES	2 <u>M</u> NO	OF DEATH?
					_		1 TYES 2 NO
25. WAS CASE REFERRED TO MEDIC	w T		00.0	105 05 05 1511 (0)			
EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (C	, , , ,		
1 YES 2 NO	1 Inpetient 2 ER/O				6 Other (Specify)		
1 Netural 5 Pending 2 Accident Investige	26a. DATE OF INJUR (Month, Day, Year		JURY W	PURY AT PRIK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCU	RED
3 Suicide 6 Could no	28e. PLACE OF INJU	RY — At home, farm, pecify)	street, factory, offic		26f. LOCATION (Street City or Town, State		Rural Route Number,
	HYSICIAN: To the best of my know.						
296. SIGNATURE AND TITLE OF CER	TIFIER //			29c. LICENSE NU	MBER	29d, DATE S	SIGNED (Month, Day, Year)
1/. B. 4klla	- Die			D 3046			1-23-1994.
30. NAME AND ADDRESS OF PERSO	WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	o, Print)	2 30-30		1.	1 43 1774.
N. B. Vellanki.	MD 9055, Chevi	rolet Dri		te 100,	Ellicott	City, I	MD 21042.
31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIG	SNATURE ALL	174				
NOV 2 8 1994	1 June						



3. TIME OF DEATH

REG. NO.

DALLIMORE, MARTLAND 2121	the death certificate be executed within mours after death. Page 6 may be retained by the hospital or atte	69	
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D3, F.O. BOA 66/60.	leat	the attending physician and completely filled in by the funeral director, page 5 should be detached for use a	distribute arises to busine accounting as seemed
7	9	he	AAA
-1	#	_	7

1. DECEDENT'S NAME (First, Middle, Last)

Mahmood Shariff

31. DATE FILED (Month, Day, Year) NOV 3 U 1994

2. DATE OF DEATH MONTH Edgar W. Brannock, Sr. Edgar W 4. SOCIAL SECURITY NUMBER Brannock 0455 Wright 29 VI. 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 213-14-1394 1 M 2 F YRS. 02/21/21 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Cambridge 1 YES XX NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? inding physician. as the burial-transit p 101 Buena Vista Avenue 21613 US 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XIX YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 5-0020 1 Never Married XX Married BY Specify: White 3 Widowed 4 Divorced WW II ETED. 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Postal Employee the medical examiner must be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Lee Brannock Dessie Blanche Bradshaw 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Betty R. Brannock 101 Buena Vista Avenue Cambridge, Maryland 21613 20a, METHOD OF DISPOSITION
1 🔀 Burlel 2 🗆 Gremation 3 🗆 Removal from State
4 🗆 Donation 14 🗓 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State emetery, cremetory or other place)
Md. Veteran's Cemetery 12/2 Hurlock, Maryland 21. SIGNATURE NERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home tomes 700 Locust St. Cambridge, Maryland 21613 23. PART (/Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on aech line IMMEDIATE CAUSE (Final disease or condition resulting in death) WD STAGE CONGESTIVE HEART DUE TO (OR AS A CONSEQUENCE OF): -WD EUMOWY traumatic event, LEROTIC CAMOW VASCULAR DISEASE SEV. YRS RTEMOSE MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEDUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, or DIVISION OF VITAL RECORDS, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? been signed by the MASS in SUPERION MEDINSTINUEN -PROBABLY AMILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TES 2 VIO OF DEATH? LUNG CA 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO [5] PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c. 1 Nameliai 2 Accident 1 YES 2 NO ВY After Investigation 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 28 is 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined DIRECTOR: / 4 Homicide item 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL (
within 72 h
TANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERPHILER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 29/94 15 11 -66 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

105 Aurora Street

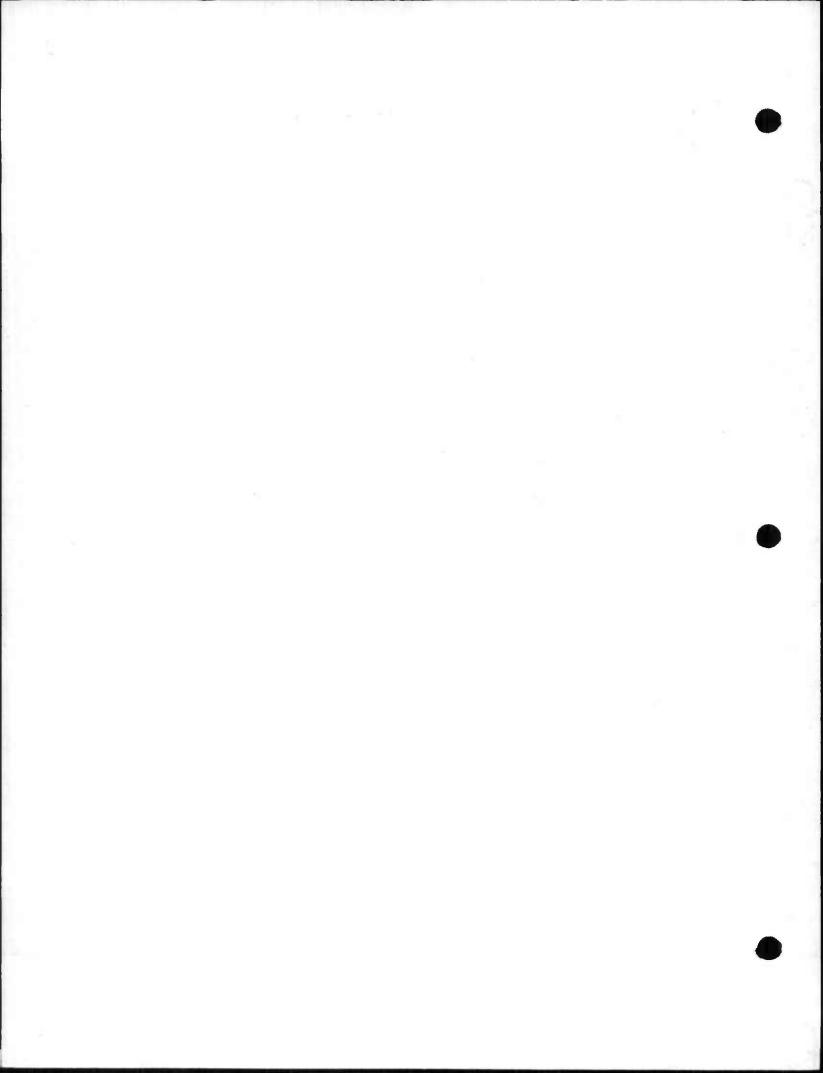
As REGISTRANT'S SIGNATURE

Cambridge, MD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

21613

Interval Between Onset and Death



Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZI TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) Gilbert	Marvin]	Buchana	n	2. DATE	of DEATH	28,199	2 3.	TIME OF DEATN
	4. SOCIAL SECURITY NUMBER 217-30-0788	1 XM 2 □ F 59	n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	Fee	of BIRTH	730,1	BIRTNPL Synty) 35	Maryland
TOR	99. FACILITY NAME (If not institution, give st D1d Indian Head Hi RESIDENCE OF DECEDENT		ence)		n Head	EATN		9c. COUNT		'N
DIRE(narles		то wн оп L oc ndian	1397					d. INSIDE CITY LIMITS? YES 2 \(\text{\background} \) NO
FUNERAL DIRECTOR	100. STREET AND NUMBER Rt. 2, Box 270				20640			U	.S.A	
B≺	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAY VIETNE	2 MNO TES	It yes, s	CENDENT OF NISPA pecity Cuben, Mexic S 2 1 NO Speci	en, Puerto	4? (Specify Yee Rican, etc.)	or No—	Black, W Specify:	American Indian, Thite, etc. White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementery/Secondary (0-12)	CATION completed) College (1-4 or 5+)	life. Do NOT use	ork done during m retired.)	ION ost of working		. KIND OF BUS		STRY	
BE COM	17. FATNER'S NAME (First, Middle, Lest) William Russel	l Buchanar	Carper	iter	16. MOTNER'S NA	AME (First,	Carper Middle, Maiden Veeks		Uni	on
TO B	190. INFORMANT'S NAME (Type/Print) Lorraine Bucha	anan	19b. MAILING	ADDRESS (Street	end Number or Rural		-	n, State, Zip Co	ode)	
	20a METHOD OF DISPOSITION 212 Burial 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	Na	PLACE AND DATE OF oth IZEYENE	Churc	h Cem.	12-1	E 20c. LO	CATION — CH Disgga	or Town,	State Maryland
	· With	MC MC	0668	Wil	liams F	uner	al Ho	me,P	.A.	n Head. N
	IMMEDIATE CAUSE (Final	omplications that caused list only one cause on each of the cause on each of the cause on each of the caused on the caused one caused on the c	ch Ilne.	t enter the m	e L	ch es cen	diec or respi	ratory srres	t,	Approximete interval Between Onset and Daath
Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
AL.	PART II. Other significent conditions	contributing to deeth be	it not resulting in	the underlying	ng ceuee given in	Part i.	24a. WAS AN PERFOR 1 YES 2	MED?	CO	TRE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)						YES 2 NO				
HYSI	EXAMINER? HOSPITAL: OTHER									
00 2 Accident Investigation M 1 YES 2 NO							e Number.			
LETED	4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only	building, etc. (Speci		at the time dat	a and place, and due	City	or Town, State)			
COMPLET		l: On the besis of examination			death occured at the	time, date			euse(e) en	d manner ee stated.
TO BE	Horish M 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, F	Print)	D-28352			► 11 /	29	onth. Day, Year)
	Krishan Mathur, M	32. REGISTRAR'S SIGNA	TURE		13 Waldo	rf,Ma	ryland	2060	3	
	DEC 0 5 199	14 July Dave	dear Rordal							DHMH-16 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
e, Last)		2. DATE OF DEATH

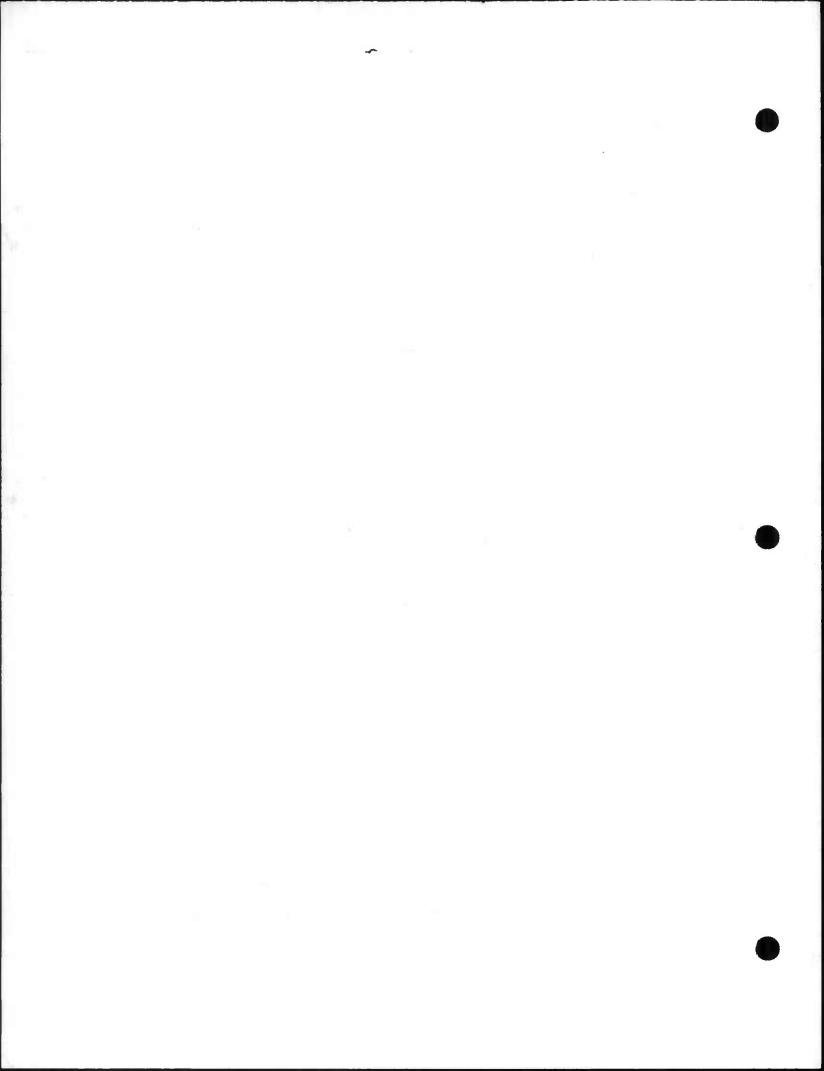
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH				
	JAMES WILLIAM BRAGG	WILLIAM BRAGG			11 DAY YEAR 2:50 P					
		The state of the s			7. DATE OF BIRTH (Month, Dey, Year) 8. BIRTHPLACE (State or Foreign Country)					
DIRECTOR	220-10-7978 1 T N 2 F 77	218			09 21 17 W VA					
	SACRED HEART HOSPITAL CUMBERLAND				ALLEGANY					
)IRE	100. STATE 10b. COUNTY MD ALLEGANY	in on a final on a conton				10d. INSIDE CITY LIMITS? 1 XYES 2 NO				
	10e. STREET AND NUMBER			ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
BY FUNERAL	10121 MASON DIXON VIEW			21529		USA				
	1 Never Married 2 W Married FORCES? 1 XYES 2	FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yee, specify Cuben, Mexicen, Puerto Ricen, etc. 1 YES 2 NO Specify:						
G	15. DECEOENT'S EDUCATION (Specify only highest grade completed)		16b. KINO OF BUSINESS/INDUSTRY							
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.)			t or working						
MP	8 DRIVER				TRUCKING					
BE CO					AME (First, Middle, Meiden Surneme) ARL SUMMERS					
5	190. INFORMANT'S NAME (Type/Print) SYLVIA M. BRAGG				CLERSLIE		21529			
	200 METHOD OF DISPOSITION 1 Removel from State Commetter	ACE AND DATE OF D	DISPOSITION (Nar	ne of	OATE 20c, LO	CATION — City or	Town, State			
	4 Donation 5 Other (Specify)	STLAWN	MEM.		/28/94 1	LaVALE,	MD			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY HARVEY H. ZEIGLER FUNERAL HOME								
	Alleyster	HARVEI H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636								
	23. PART I. Enter the diseases, a complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arreat, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) 6. CACCOMMA OF UNG 2 475									
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate causa. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL (PART II. Other significent conditions contributing to deeth but n	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS								
MEDIC/	HYPO ADROLACISM: END STAGE RENAR 1 YES 2 INO PERFORMED? 1 YES 2 INO PERFORMED? 1 YES 2 INO AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 INO									
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN									
SIA	25. WAS CASE REFERREO TO MEDICAL 26. PLACE OF DEATH (Check only one)									
, Si	HOSPITAL:	OSPITAL: A Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)								
PHYSICIAN:	27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF		RY AT	26d. OEŞCRIBE HOW I	NJURY OCCUREO				
B⊀	1 Netural 5 Pending 2 Accident Investigation	M 1 YES 2 NO								
	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 26e. PLACE OF INJURY — At home, term, street, factory, of building, etc. (Specify)			Tice 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the lime, date end place, end due to the cause(e) end menner as stated.									
296. DICENSE NUMBER 296. DICENSE NUMBER 296. DATE SIGNED										
ROBERT WELIK, MD 902 SETON DRIVE CUMBERLAND, MD 21502										
										31. DATE FILED (Month, Day, War) 20. REGISTRAR'S SIGNATUR
	NOV 29 1994 Jabi danibarda	NEWS .								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit perm be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)				2.1			2. DATE OF DEATH S. TIME OF DEATH MONTH DAY YEAR			
	MARIAN	DELORES		BURKE		NOVEMBER 29, 1994				:40 P M	
				ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont)	OF BIRTH	0.	BIRTHPL Country)	ACE (State or Foreign	
- 1	370 30 2070		68 YRS.				2 , 1			ington,DC	
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL RESIDENCE OF DECEMENT		1	96. CITY, TOWN OR LOCATION OF DI			EATH 9c, COUNTY OF DEA			тн	
REC	10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
	Maryland Charles		W.	Waldorf						YES 2 NO	
FUNERAL	100. STREET AND NUMBER			101. ZIP CODE			10g. CITIZEN OF W			AT COUNTRY?	
NE	3006 Gallery Place 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI			20602			U.S.A.				
	t Never Married 2 Married TORCES? 1 YES, GIVE WAR OR DATES TORCES? 1 YES, GIVE WAR OR DATES		2 X NO	If yes, sp	ecify Cuban, Maxica	an, Puarto Rican, atc.) B			Black, \	- American Indian, White, etc.	
BY			IES	t ☐ YES 2 🙀 NO Specify			L. L.			White	
COMPLETED	(Specify only highest grade completed) (Give			ve kind of work done during most of working				. KIND OF BUSINESS/INDUSTRY			
	Elementary/Secondary (0-12) C	College (1-4 or 5+)	life. Do NOT use re	etired.)	•		7.7				
M	1. 1. 17. FATHER'S NAME (First, Middle, Last)	Homemaker					lome				
					Edna						
8				Edna Wright MALING ADDRESS (Street and Number or Rural Route Number, City or Tow				Ruppel			
2	Jacqueline Burk	е			35 Wald						
	20a, METHOD OF DISPOSITION	20b.1	PLACE AND DATE OF C	DISPOSITION (Na	me of	DAT	F 20c. LO	CATION — CIN	or Town	, Stata	
	1X Buriel 2 Cremetton 3 Removal from Stata Commetton or other (Specify) Mary Land Veterans Cem 12/2 Cheltenham, MD										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00817 Arehart-Echols Funeral Home, Inc.										
,	Janton C. Coho III P.O. Box 567 La Plata, MD 20646										
	23. PART I. Enter the diseases, Dr com shock, Dr heert fellure. List	plications that caused	the deeth. Do not	enter the mo	de of dylng, suc	h as card	flec or respi	ratory arrea	1,	Approximate interval Between	
	Onest a							Onset and Death			
	disease or condition resulting in death) a. Lyne 6 astyratistal fleling										
_	DUE TO (OR AS A CONSEQUENCE OF):							1			
CERTIFICATION	Sequantieily liet conditione, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE DF):										
CA	ceuse. Enter UNDERLYING CAUSE (Disease or Injury										
E	that initiated events resulting in death) LAST										
CER	d										
AL	PART II. Other significent conditions co	ontributing to deeth bu	t not reculting in t	ha underlying	ceuea given in	Part I.	24s. WAS AN			ERE AUTOPSY FINDINGS MILABLE PRIOR TO	
						1 YES 2	COI		OMPLETION OF CAUSE F DEATH?		
PHYSICIAN: MEDIC						1	☐ YES 2 ☐ NO				
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
S		OSPITAL:		THER:							
HYS	1 YES 2 NO t	28a. DATE OF INJURY									
	1 Natural 5 Pending (Month, Day, Year)			INJURY WORI				INJUNIT OCCURED			
D BY	2 Accident Investigation 3 Suicida 6 Could not be 28a. PLACE OF INJURY — At home, farm, building ster (Specific)						281. LOCATION (Street and Number or Rural Route Number,				
E	4 Homicide determined building, atc. (Specify) City or Town, State)										
COMPLETED	29a. CERTIFIER (Check only Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										
OM	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and menner as stated.								nd menner as stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER JULIAN			29c. LICENS					TE SIGNED (Morth, Day, Year)		
TO B				D-21031			► 11/3U			7-1	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL LEATHERWOOD, M.D. WALDORF MEDICAL PARKP.O.BOX249 WALDORF, MARYLAND20604								20604		
	DEC 0 2 1994 July de Marie Parley 1994 July de Mullar Randell										



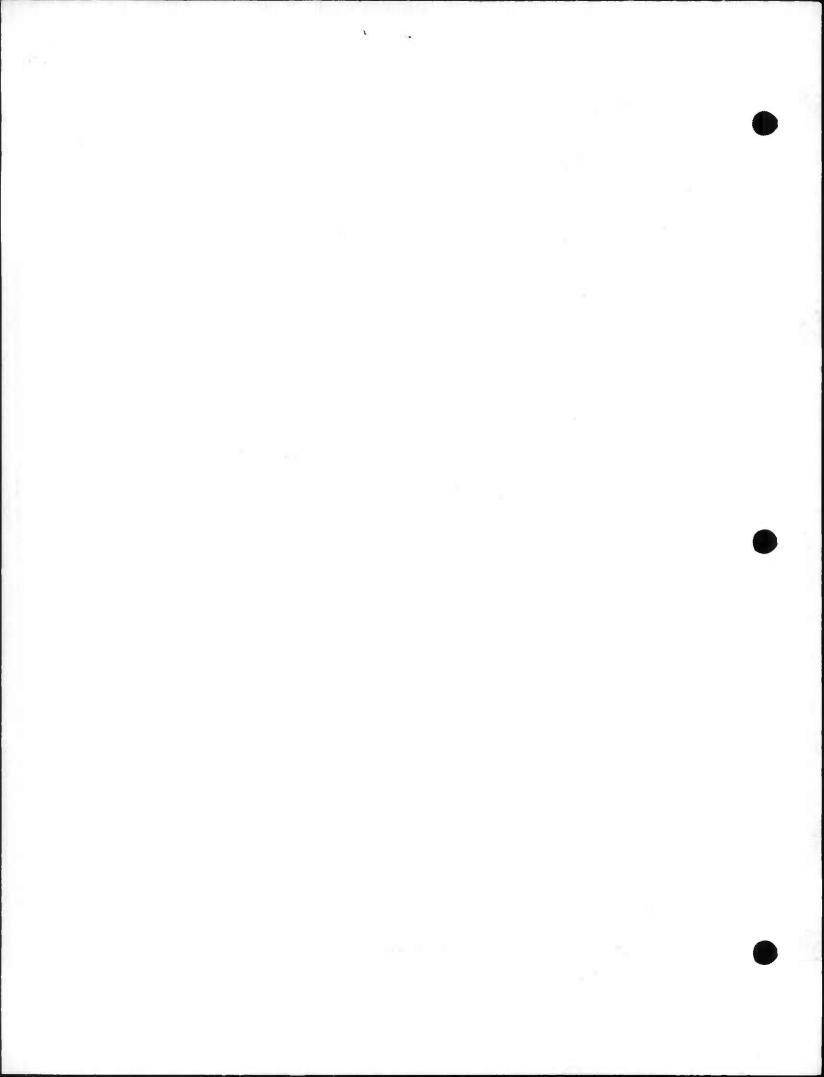
		REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO).		
		1. DECEDENT'S NAME (First, Middle, Lest) WILLIAM HE	BIIRKI	HEIMER			2. DATE OF DEATH	^{Mγ} 22 10β7	3. TIME OF DEATH 5:25 P M	
/		4. SOCIAL SECURITY NUMBER	TA.B.TA	E (In yrs. last birthday)	IF UNDER 1 YEAR	R IF UNDER 24 HRS.	7. DATE OF BIRTH		PRTHPLACE (State or Foreign	
3 should		217-05-2102	1 M 2 □ F 83	YRS.	MONTHS DAYS		(Month, Day, Year) Feb. 26,	Co	ountry)	
shoule	_	9a. FACILITY NAME (If not institution, give str			9b. CITY, TOW	N OR LOCATION OF D		9c. COUNTY O		
ci .	CTOR	THE JOHNS HOP	KINS HOSPI	TAL	BALIT	MORE CITY	<u> </u>			
Pages 1,	표	10e. STATE 10b. COUNTY		10c. Cl	TY, TOWN OR LO	CATION			10d. INSIDE CITY	
.≒. &	DIREC		larford	<i>I</i>	berdeer	1			1 YES 2 NO	
it permit,	RAL	10e. STREET AND NUMBER				101. ZIP COOE 21001			OF WHAT COUNTRY?	
cian. Ltransi	FUNER	635 Gilbert Road	12. WAS DECEDENT EVER	2. WAS DECEOENT EVER IN U.S. ARMED 13, WAS			NIC ORIGIN? (Specify Ye	U.S.A		
IND ZIZIS-00Z0 hospital or attending physician. tached for use as the burial-transit	ВҰ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			nic Official? (Specify Yearn, Puerto Ricen, etc.) fy:	В	ACE — American Indian, Black, White, etc. Specify: White	
	COMPLETED	15. DECEDENT'S EOUC. (Specify only highest grade of	ATION completed)	(Give kind of	S USUAL OCCUPA work done during	ATION most of working	16b. KIND OF BU	ISINESS/INOUSTR	Y	
		Elementary/Secondary (0-12)	College (1-4 or 5+)	Self en	,		Dairw	Farmer		
AND the hospit detached once.		17. FATHER'S NAME (First, Middle, Last)	0	Dett en	iptoyea	18. MOTHER'S NA	ME (First, Middle, Maiden			
# 8 A	ш	UNK				Chr	istina UNK	,		
Sho sho	TO B	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox			
40	-	Mrs. Marie A. Bur					oerdeen, M			
0 9 8 2		20e. METHOD OF DISPOSITION 1 Strict Burlel 2 Cremetion 3 Remon 4 Donetion 5 Other (Specify)	val from State	one PLACE AND DATE	other place)		1	OCATION — City of		
Page al direct		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	lar TOTU M	22. NAME	AND AGORESS OF FA				
SAL r death ne fune al.		BustenAr	rylligi	Lesber	Aber	deen, Mai	Funeral I cyland 21	001–3399	.A.	
ours afte d in by th or remov		23. PART i. Enter the diseasea, or co ahock, or heert feliure. L	mplicatione that cause let only one cause on	ed the death. Do eech line.	not enter the r	node of dying, suc	ch as cerdiec or resp	iratory erreet,	Approximate interval Between	
- 23 e-r		iMMEDIATE CAUSE (Fine) disease or condition	01.01	7. a. s. a. L	e 0	=1.	3 /		Onset and Death	
ted within completely al, cremati, event, t		resulting in death) a	adult K	A CONSEQUENCE O	OF):	isuus ?	rznaron	A.C.	curas	
executed within and completely o burial, creman matic event,	Z	Sequentially list conditions, b.	Pneum	onia					2 hwh	
Pe De lor por por por por por por por por por p	ERTIFICATION	Sequentielly list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury)								
ertificate ng physical price of the price of	FIC	CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):								
이 함호 등	E	resulting in death) LAST								
at the death by the atte and Mental y injury,	O	PART II. Other aignificent conditiona	contributing to death	but not resulting	in the underly	ing cause given in	Part i. 24s. WAS AN	AUTOBOY	24b. WERE AUTOPSY FINDINGS	
	EDICAL			out not recently	m the diderly	ing cause given in	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE	
3 8 5 8 K	MED						- These	2 🗆 NO	OF DEATH?	
taw requires been since the control of the control	AN:	DID TOBACCO USE CONTR	BUTE TO CAUSE	OF DEATH Y	ES NO	UNCERTAI	N 🗆			
N: The law ficate has State Dep	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSPITAL:	26. PLACE OF DEA	OTHER:	10)				
SICIAN: The Certificate of the State	PHYS	1 TYES 2 NO	28e. DATE OF INJURY		4 - Nursing He	ome 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW	IN HIEV OCCUPES		
NG PHYS fter this cath with		1 Natural 5 Pending Investigation	(Month, Day, Year)		JURY	WORK?	200. DESCRIBE NOW	NJOH! OCCORED	,	
N A P S	D BY	3 Suicide a Could not be	28e. PLACE OF INJUR building, etc. (Sp	IY — At home, term,	streat, factory, of	fica	28t. LOCATION (Street City or Town, State)	end Number or Rui	ral Route Number,	
ATTEN RECTOR: Ins after	ETE	4 Homicide detarmined					Only or lown, orang			
TAL OR A AL DIREC 72 hours If Item			AN: To the beet of my kno							
	COMPL	2 MEDICAL EXAMINER	On the besie of examinati	on end/or investigati	on, in my opinion	, death occured at the	time, date end piece, er	nd due to the caus	se(s) and menner ee stated.	
를 를 를	BE	296. SIGNATURE AND TITLE OF CERTIFIE	Lord			29c. LICENSE NUI			NED (Month, Day, Year)	
263	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF O	EATH (ITEM 27) (Type	a, Print)	1 L46	FE STREET	11/2	23/94	
		Marcus O.	But le	~			, MD 21287			
_		NOV 25 1994	Jama d'audie	war hardall						

ital or attending physician. I for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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te be executed within rours after death. Page 6 may be retained by the hospir	sician and completely filled in by the funeral director, page 5 should be detached brior to burial, cremation, or removal.	traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle	Lastj				2. DATE OF DEATH	-	3. TIME OF DEATN			
	FLORENCE 1	FRANCES BAYE	R			NOV. 23	1994	8:44 PM M			
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		THPLACE (State or Foreign			
	220-01-3364 1 73 Yes June 20, 1921 Mary										
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN										
OR	Lorien Nursing & Rehabilitation Cnt. Belcamp, Maryland Harford										
DIRECTOR	RESIDENCE OF DECEDER	COUNTY	10c. CIT	Y. TOWH OR LOCATI	ON			10d, INSIDE CITY			
E C	Maryland	Harford		Joppa				LIMITS?			
	10e. STREET AND NUMBER				ZIP CODE		10a. CITIZEN OF	1 ☐ YES 2 💢 NO WHAT COUNTRY?			
ER/	1621 Dugan	Drive			21085		U.S.				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS DECE	NDENT OF NISPAN	IC ORIGIN? (Specify Yes	or No.— 14. RA	CE — American Indian			
ВУ Е	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YE			cify Cuben, Mexice 2 NO Specify	n, Puerto Ricen, etc.)		ck, white, etc. Ich: White			
8	15. DECEDENT (Specify only highes	S EDUCATION	16e. DECEDENT'S	USUAL OCCUPATIO	N	16b. KIND OF BU	SINESS/INDUSTRY				
COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)	t or working						
MP	8		Home	emaker		Но	me				
8	17. FATHER'S NAME (First, Middle, Li				18. MOTHER'S NA	ME (First, Middle, Maiden					
86	Gerald Jeffer		400 1444 144		Marga		herine	Schaech			
5	John C. Bayer	y				Poute Number, City or Tow Da, Maryla		35			
1 1	20s. METHOD OF DISPOSITION	1	20b. PLACE AND DATE O	OF DISPOSITION (Nat	ne of	- DATE 20c. LO		Town, State			
	1 Surfal 2 Gramation 3 5 4 Donation Other (Specifi	Herodysi from State	Gardens C	faith	Cemeter	y 1994 Ba	ltimore,	Maryland			
	21. SIGNATERIN OF FUNERAL SERV	topytensyte /	/	22. NAME AN	D AGORESS OF FAC	CILITY		Jan 2 3			
	>14000111V	1.1/c(8/110)	4 711			omas III F		iome P.A. Taryland 2100			
	23. PART I. Enter the disease	a, of complications that caus	sed the death. Do n	ot enter the mod	te of dying, such	as cardiac or reap	ratory erreat,	Approximate			
	shock, of heart fe	lidre. List only one cause or	eech line.			**		Interval Between Onset and Death			
	disease or condition resulting in deeth)	a. (erels	no vasu	lor	Geo. no			Onset and Seath			
	readiting in deeth)	DUE TO (OR A	S A CONSEQUENCE OF	7:	TICCI DE						
Z	Sequentially list conditions,	6 b.									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	S A CONSEQUENCE OF	7):							
윤	CAUSE (Disease or Injury that initiated eventa	C. DUE TO (OR A	S A CONSEQUENCE OF	<u></u>							
E	resulting in death) LAST	201		,				į į			
		0.									
CAL	PART II. Other algorificant con	iditions contributing to death	but not resulting i	n the underlying	cause given in	Part I. 24s. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
8	Sirvila	u auce	7 000	ceau		1 🗆 YES 2	KNO	OF DEATH?			
MEDI			1			_ /		1 - YES 2 -			
z			,								
SICIAN:	25. WAS CASE REFERRED TO MEDI EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (Che	eck only one)					
1×S	1 YES 2 NO	1 Inpetient 2 ER/O		4 Offursing Nome		6 Other (Specify)					
РНУ	1 Natural 5 Pendin	28e. OATE OF INJUR (Month, Day, Yea		URY WOR	RK?	28d. OEŞCRIBE NOW I	NJURY OCCURED				
à	2 Accident Investig	ation	IRY — At home, ferm, s		ES 2 NO	244 1 2247201 (2		10			
윤	3 Suicide 6 Could / 4 Homicide determi	building, etc. (S	pecify)	River, lactory, diffice		City or Town, State)		Houte Number,			
COMPLET	290. CERTIFIER 1 CERTIFYING	PHYSICIAN: To the best of my kn	owledge death occurr	ed at the time, date	and plane, and due	to the source to read and	3035				
ğ		(AMINER: On the basis of examina						o(s) and manner as stated.			
	29b. SIGNATURE AND TITES OF CE)	1	29c. LICENSE NUM			ED (Mogth, Day, Year)			
8	Welen.	hula			0283	3 9	D (1 2	5/94			
임	30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAUSE OF	OEATN (ITEM 27) (Type,	Print)	100	<u> </u>		1.7			
	cinb y	PREMIEH	3101	Wheel	None	& Bel	ain	1021011			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE		(
	NOV 23	1994 Juli Da	who hardall								
	NOV 25	1994 Jahn Daw	dear Rardall					DNMH-16 Rev t/89			

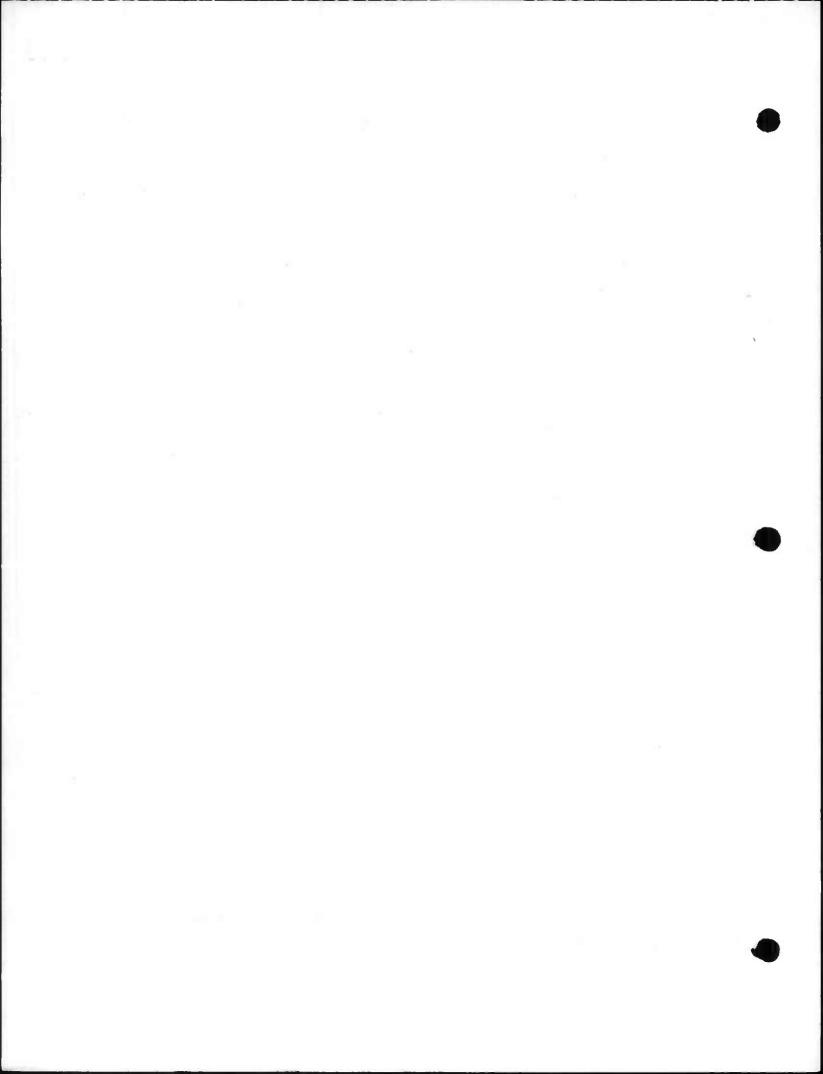


ifal or attending physician. 3 for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
ir death. Page 6 may be retained by the hospit	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospit
DALLINOUE, IMARTERIA	

								94	36845
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN			HEALTH AND I	MENTAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) DONALD	Р.		ВОЕНМ		2. DATE OF DEATH DEC. 0	6 19	9 4 AR S	2:21 A M
	4. SOCIAL SECURITY NUMBER 217 58 0975	1 M 2 □ F 44	rs. lasi birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 25	950	8. BIRTHPL Country) Mary]	
TOR	99. FACILITY NAME (If not institution, give si MARTINS GRANT RESIDENCE OF DECEDENT	,			N OR LOCATION OF DE	ATH		NE AI	RUNDEL
DIRECTOR	10e. STATE 10b. COUNTY	Arundel	ownsvi				1	Od. INSIDE CITY LIMITS? VES Z NO	
FUNERAL	100. STREET AND NUMBER 1524 St. Stepher	ns Church Road			101. ZIP CODE 2103:	2			at country? States
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES	NO	If yee,	ECENDENT OF HISPAN apacity Cuben, Mexica ES 2 NO Specify	IIC ORIGIN? (Specify Yon, Puerto Ricen, etc.)	ee or No-	Black, \	- American Indian, White, etc. White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		O. DECEDENT'S (Give kind of we life. Do NOT use Serge	ork done during e retired.)	TION most of working	16b. KIND OF BU	Pol:		
BE CON	17. FATHER'S NAME (First, Middle, Last) Donald P. Perkir	าร				ME (First, Middle, Meide eth J. Jac			
10	190. INFORMANT'S NAME (Type/Print) Deborah Jean Boel	nm				hurch Rd.			le,MD. 2103
206. METHOD OF DISPOSITION 1 R Burlet 2 Cremetton 3 Removal trom State 206. PLACE AND DATE OF DISPOSITION (Name of Location - City or Town, State Property of Date of Congression of Con									aryland
									715
ahock, or heart failure. List only one cause on each line.							Approximate interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
PHYSICIAN: MEDICAL (PART II. Other aignificant condition						RMED?	0	PERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? PES 2 NO
CIAN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEATH	H (Check only on		1 🗆 📗		<u></u>	
PHYSI	1 N YES 2 □ NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpatient 28e. DATE OF INJURY FUN (Month, Day, Year)	nt 3 🗆 DOA	OF 28c. I	NJURY AT VORK?	6 Other (Specify) 28d. DESCRIBE HOW	LOCA		REET
ВУ	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	260. PLACE OF INJURY - 1 building, etc. (Specify)	091	5 M 1	YES 2 NO	SUSJEUT SLOT SUJ. 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)			
COMPLETED			e, death occurren	d at the time, da	ite end place, end due	Matin	S G	rant	2
	2 MEDICAL EXAMINES 29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the besis of examination en	d/or investigation	n, in my opinion	death occured at the		_		fonth, Day, Year)
TO BE	30. NAME AND ADDRESS OF PERSON WHO	ffe al	(ITEM 27) (Type	Print)	O.C.M.				, 1994
	David R	Power 11	1 Peni		et, Bal	timore,	Mary	land	21201
	DEC 1 4 1994	32. RAGISTAAR'S SIGNATU	all						

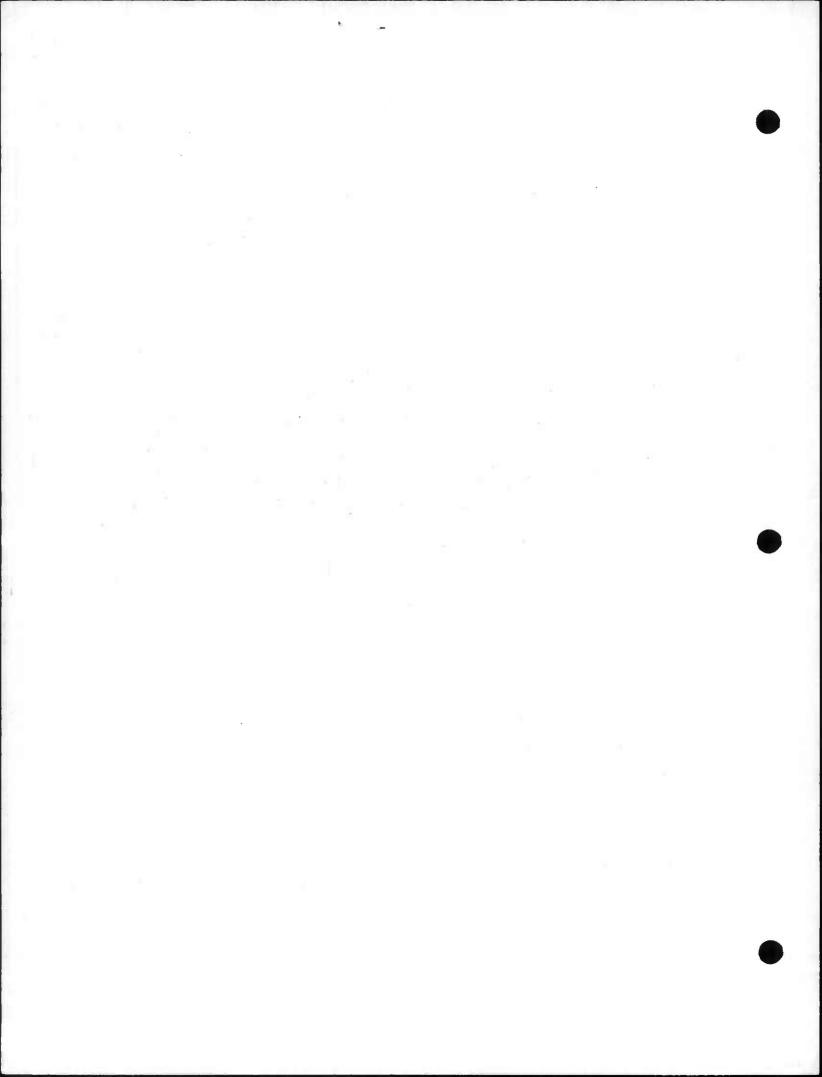


ling physician. the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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the hospital	detached ft	
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death. Page	funeral dire	1
hours after of	ed in by the	- ladina
d within 24	mpletely fill, cremation.	Appropriate Afterna
be execute	ician and co	- 44-
th certificate	anding phys Hygiene pr	
hat the deal	d by the att	The factories
w requires t	been signer	
JAN: The lan	rtificate has	14
JING PHYSIC	After this ce death with th	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the flied within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	CONTRACTOR OF the Contract of
HOSPITAL	FUNERAL within 72	
TO THE	TO THE	- Contract

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		FOR STATE REGISTRAR		STATE OF I	MARYL		DEPAR					MEI	NTAL HYGIEN REG. NO.	E			
		1. DECEDENT'S NAME (First, Middle) NIDRED		ICE	13	EAL	ICH	AME)			1.1	DATE OF DEATH DA	3 0	YEAR /	3. TIME OF	DEATH A. M
		4. SOCIAL SECURITY NUMBER		5. SEX 1 ☐ M 2 🔀 F	8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS				R 24 HRS.	7. [Month, Day, Year)		Count		or Foreign		
		217-14-2057 9a. FACILITY NAME (If not institution		YRS.	9b. CITY	. TOWN (OR LOCAT	ION OF DE		ly 27, 1	922	Mar INTY OF D	yland				
90		FALISTON GE.	TAC		-	1157					.)	121-					
l H		10e, STATE 10b, COUNTY					10c. CIT	Y, TOWN C	OR LOCA	TION						10d. INSIDE	
2	5	Maryland Harford									pingo	ion	<u> </u>			1 TYES	2 X NO
FDAI		3802 Washir				10	f. ZIP COD	Œ	2	1009	10g, CIT		WHAT COUNT	RY?			
I I		11, MARITAL STATUS	ngto	12. WAS DECEDEN	IT EVER IN	U.S. ARI	MED					HC O	RIGIN? (Specify Yes	or No—	US 14. RAC	E — American	Indian,
Ş	- 11	1 Never Merried 2 Merried FORCES? 1 YES 3 Widowed 4 Divorced FYES, GIVE WAR OR DATE					0				en, Mexice Specify		erto Ricen, atc.)		Spec	k, White, etc. ://y:	
6	- 1	15, DECEDEN	NT'S EDUC	ATION		18e, DE	CEDENT'S	USUAL O	CCUPATIO	ON			16b. KIND OF BUS	UNESS/INI	DUSTRY	whit	te_
1 1	ill	(Specify only high Elementary/Secondary (0-12)	hest grade	College (1-4 or 5	+)	(Gi	ve kind of a Do NOT us	vork done	during mo	ost of work	ing		TOD. KIND OF BOO	AITE SO / II T	bosimi		
once.				3		Co	ntra	ct S	peci	alis	st		U.S.	Gov	ernn	ent	
		17. FATHER'S NAME (First, Middle, Alfred Burton	,	20									atherine	,	lap]]		
fled a		190. INFORMANT'S NAME (Type/Pr				196	. MAILING	ADDRESS	S (Street a	1			Number, City or Town				
be notiff		Patricia G. Be	eaucl	namp		1	302E	Clo	ver	Val1	ey W	lay	, Edgewo	od,	Mary	land	21009
must b	1	20s, METHOD OF DISPOSITION 1 № Burlel 2 ☐ Cremation 3		Val from State			ND DATE					T				own, State	7
E		The Burlet 2 Cremation 3 Removal from the Company of Allens of Faith Cemetery 12-3-91 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LIGHNEY 22. NAME AND ADDRESS OF FACILITY															
examiner		Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road Abingdon Md 21009 23. PART L. Enter the diseased or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or resolution arrest. Approximate															
medical	23. PART 1. Enter the diseases/ or complications that cadsed the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, ehock, or heart failure. List only one cause on each line.											Appro					
th.	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. + PCVCAVDIA BUE TO (OR AS A CONSEQUENCE OF):										Onse	t and Death					
other traumatic event,			_	A GUE TO	(OR AS A	CONSEC	VC M		1	14 6							
or other traumatic		Sequentially list conditions, if any, leading to immediate		DUE TO	(OR AS A	CONSEC				1	•	_)		1		
Pr tra		cause. Enter UNDERLYING CAUSE (Disease or Injury	4 .		oni	_	OK	25%	mo	n	4 /	Du	mou	dry	dis	ruse	
or oth		thet initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSEC	ONSEQUENCE OF):										
O.Y.			-													+	
shows any injury, MEDICAL CI		PART II. Other eignificent co	onditions	s contributing to	deeth b	ut not re	suiting	in the un	derlyin	g ceuse	given in	Part	i, 24a. WAS AN PERFOR		248	AVAILABLE P	PRIOR TO
hows any inj												—	1 TYES 2	X NO		OF DEATH?	
3 sho	. 11	DID TOBACCO I	USE C	ONTRIBUTI	E TO	CAUS	SE OF	DEAT	TH Y	ES 🗷) NC) [7			1 TYES 2	E [] NO
SICIAN		25. WAS CASE REFERRED TO MEI EXAMINER?		HQSPITAL:				OTHER	28. PI	_	DEATH (Ch	eck o	nly one)				
0 ≥		1 YES 2 NO		1 Inpatient 2		atient 3		4 🗆 Nun	sing Horr		esidence		Other (Specify)				
ě 0		1 Natural 5 Pendi	ling rtigation	28e. DATE OF (Month, E			28b. TIM	URY M		IURY AT ORK? YES 2 [NO NO	28d	. DESCRIBE HOW IF	NJURY OC	CURED		
- C		3 Suicide 8 Could		28e. PLACE C	F INJURY	— Al hoi	ma, term,	street, fect	ory, offic			281.	LOCATION (Street a City or Town, State)	nd Numbe	r or Rural	Route Number,	
m 28 ETE			mined					_					Only Or Town, State)				
ANT: If Ite		one) —											e ceuse(e) end man				
S INT	1	2 MEDICAL I	EXAMINE	1: Un The beets of e	xamination	and/or li	nvestigatio	n, in my o	pinion, d				date and piece, en				
IMPORTANT: If Item TO SE COMPLE	- 18	SILLIM	W	wa	M	V				29c. LIC	LY/	DER	67	29d. DAT	11/3	0/94 0/94	Year)
	STANLEY KMAN 1308 BUSINESS WAY, #102, EDGEWOOD, MD.										. 210	40					
		31. DATE FILED (Month, Day, Year) DEC	1 199	32. REGISTRA	Dave	ATURE			/								



death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL

	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit permit. Pages 1. 2. 3 should	Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
DIVISION OF VILAE RECORDS, P.O. BOX 68/60,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deatl	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the atte	be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, i	

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	FOR 1 - STATE REGISTRAR	STATE OF M			RTMENT CATE				MENTAL HYGIEN	-		
	1. DECEOENT'S NAME (First, Middle	1 1	rande			. 01	DEA		2. DATE OF DEATH MONTH D		YEAR GY	3. TIME OF DEATH ()4:4541
100	4. SOCIAL SECURITY NUMBER 213-16-1548	5. SEX 1 💢 M 2 🗌 F	8. AGE (In yrs. les	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH JUNE 17,	1910	B. BIRTH	IPLACE (State or Foreign Lyland
OR	98. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital 96. CITY, TOWN OR LOCATION OF DEATH Frederick											EATH LCR
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland Frederick 100. CITY, TOWN OR LOCATION BWrkitts ville											
IERAL	100. STREET AND NUMBER 202 East Main	Street				101	217				J.S.	1 🖾 YES 2 □ NO WHAT COUNTRY? 4.
BY	11. MARITAL STATUS 1 Never Married 2 Marrie 3 Wildowed 4 Divorced		T EVER IN U.S. AR YES 2 0	MED	- 1	f yes, spe		n, Mexica	IIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)	or No-	14. RACI Bleck Spec	E – American Indian, k, Whita, aic. My: White
COMPLETED												
BE CON	17. FATHER'S NAME (First, Middle, William H. Br						18. MOTI	her's nai	ME (First, Middle, Maiden Pryor	Surname)		
5	190. INFORMANT'S NAME (Rype/Pri Florence Bray		2	02 E	. Ma	(Street a	nd Number	or Aural F Burk	itts Ville,	n, Store Zig	2171	8
20d/METHOD OF DISPOSITION 1 Deutsi 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of State Sequence) Place and Date of Disposition (Name of Sequence) Place									Maryland			
	21. SIGNATURE OF PUMERAL SER	& Lacket	ie		Ric	cket		uner	al Home N	lyers	vill	Street e, MD 21773
	23. PART I. Enter the disease ahock, or heart find the service of	es, or complications that allure. List only one cau a. Blade DUE TO	se on each line				de of dy	ing, auch	h as cardiac or respi	iratory an	rest,	Approximate Interval Between Onset and Death
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST										1 year	
PHYSICIAN: MEDICAL CER	PART II. Other significant co	enditiona contributing to							Part I. 24e. WAS AN PERFOR	MEO?	24b	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
IAN: N	DID TOBACCO 25. WAS CASE REFERRED TO MED		E TO CAU	SE O	F DEA	-	YES [] NO	ock only one)			1 123 2 100
HYSIC	EXAMINER? 1 VES 2 NO 27. MANNER OF CEATH	HOSPITAL: 1 Inpetient 2		☐ DOA	_	l:	6 5 □ Re		6 Other (Specify)			
B	1 Natural 5 Pendit 2 Accident Investi 3 Suicide 8 Could	M M	1 🗌 Y	RK? 'ES 2] NO	28d. DESCRIBE HOW INJURY OCCUREO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
BE COMPLETED	one) 2 MEDICAL E	G PHYSICIAN: To the best of EXAMINER: On the basis of a	camination and/or i				29c. LICE		to the cause(s) and mar time, deta and placa, an	d due to th	ne cause(a	(Month, Day, Year)

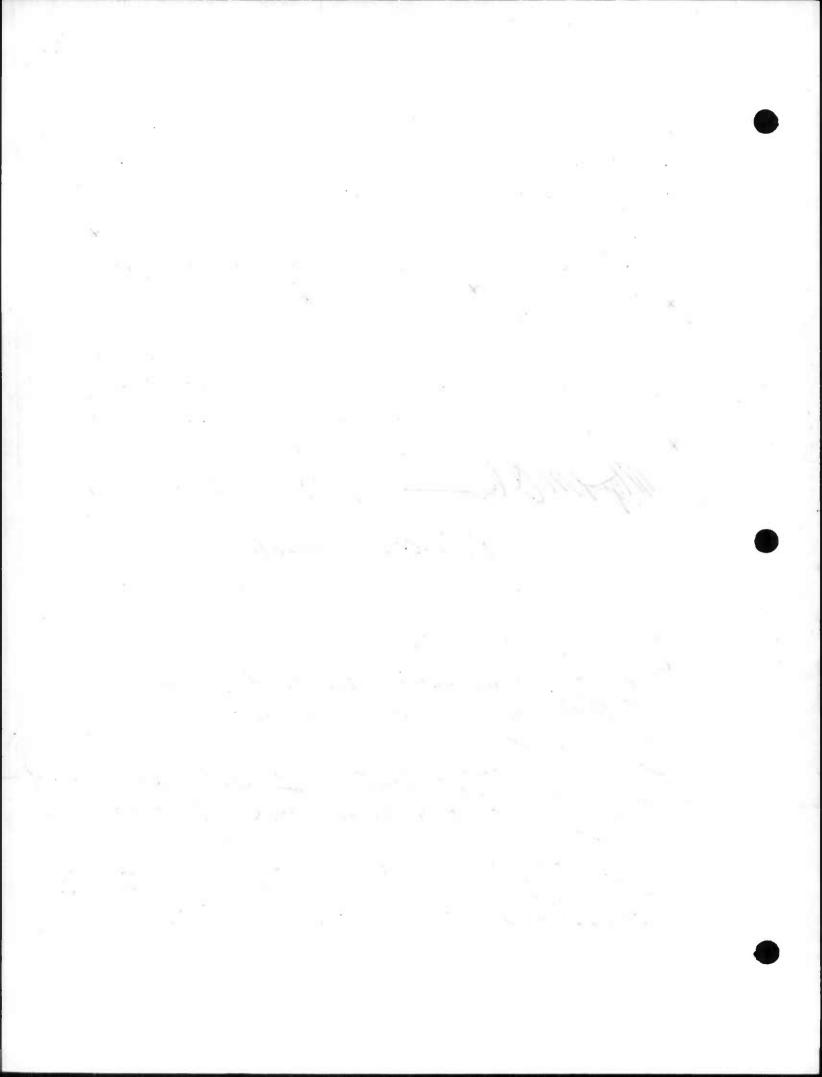
Stern Kathleen Ninth

31. DATE FILED (Month, Day, Year)

29d. DATE SIGNEO (Month, Day, Year) 11/94

	REGISTRAR 1. DECEDENT'S NAME (First, Middle	0 1		IFICATE	OF DEATH	2. DATE OF DEATH). DAYYI	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	STUAR?	8. AGE (In yrs. last birtho	RUG	EAR IF UNDER 24 HRS.	7 DATE OF BURTH	29 9	BIRTHPLACE (State or Foreig			
	220-46-2200	1 🗆 M 2 💢 F	95 YR	MONTHS F	MYS HOURS MIN.	Aug. 5, 18	899 P	country) ennsylvania			
DIRECTOR	8a. FACILITY NAME (If not institutio			OWN OR LOCATION OF D		9c. COUNTY	OF OEATH				
	Fahrney Keedy		ne	Boor	nsboro		Washi	ngton			
		Vashington	This is	ary, rown on				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
	100. STREET AND NUMBER			-501001	101. ZIP CODE			OF WHAT COUNTRY?			
FUNERAL	823 The Terrac				21740		US				
BE COMPLETED BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	FOROTOR 4	T EVER IN U.S. ARMED YES 2 X NO AR OR DATES	lf y	S DECENDENT OF HISPA es, specify Cuban, Maxic YES 2 NO Speci	an, Puerto Rican, etc.)	14.	RACE — American Indian, Black, Whita, atc. Specify: White			
		T'S EDUCATION set grade completed) College (1-4 or 5 +	(Give kind	of work done during the property of the proper	JSINESS/INDUS	TRY					
	17. FATHER'S NAME (First, Middle, I	Lest)		ionenake							
	Emmert Chris	stopher Stu	uart								
TO B	19a. INFORMANT'S NAME (Type/Pri		19b. MAI 1150	The Ter	Trace Has						
TC	, , ,										
	20s. METHOD OF DISPOSITION 1 M Burlai 2 Cremation 3 Removel from State 20s. PLACE AND DATE OF DISPOSITION (Name of Speciety, Page 4 Donation 5 Other (Speciety, Page 4 N. Minnich 21. Signature of Funeral Service Licensee 22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomaco										
	21. SIGNATURE OF FUNERAL SER	MANACH			tomac Stree						
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between										
CATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	To Au	COR AS A CONSEQUENCE	tic fear	it Pare	ee_		Defined and the second of the			
CERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.										
	PART II. Other significent co	onditions contributing to	//	-11		Part I. 24a. WAS A	N AUTOPSY PRMED?	24b. WERE AUTOPSY FIND AWAILABLE PRIOR TO			
: MEDICAL	_ Chinic B	eain fyr	dire un	Il fle	eactiv	1 YES		COMPLETION OF CAL OF DEATH?			
SICIAN:	25. WAS CASE REFERRED TO MED EXAMINER?				26. PLACE OF DEATH (C						
YSIC	1 YES 2 NO		ER/Outpatient 3 🗆 DO	OTHER:	g Home 5 - Residence	6 Other (Specify)					
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pendi 2 Accident Invest	Igation	ny, Year)	INJURY M	IC. INJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCUR	NEO			
0	3 Suicide 5 Could 4 Homicide determ	not be building.	F INJURY — At home, fa etc. (Specify)	rm, street, factory	, offica	281. LOCATION (Street City or Town, State	and Number or . e)	Rural Route Number,			
BE COMPLETE	anal surj										
B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
ш				. ,	orator M	85/ oruland 2	17/0	129/94			
BE	30. NAME AND ADDRESS OF PER: Edson B. Mood 31. Date Filed (Month, Day, Year)	dy 1190 Mt.	se of oeath (Item 27) Aetna Roa r's signature	. ,	erstown, Ma	aryland 2	1740	129194			

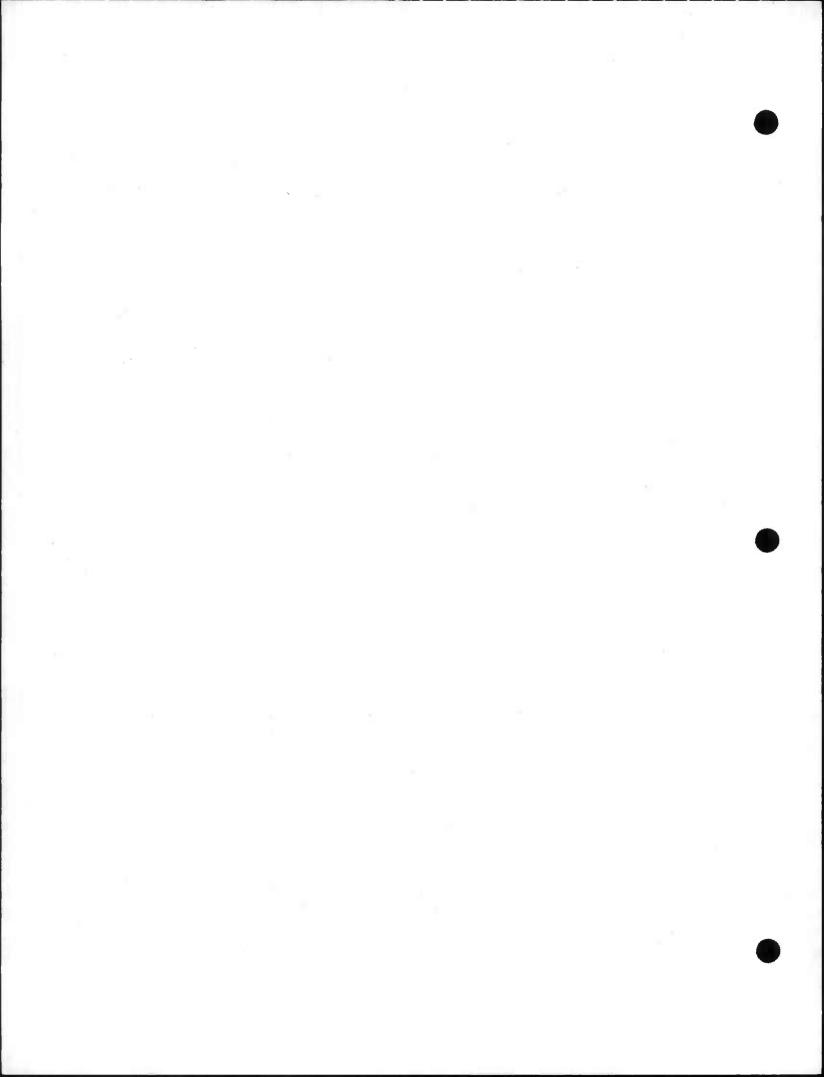
		REGISTRAR				F DEATH	REG. NO					
		1. DECEDENT'S NAME (First, Middle, Lest,	BakerEzra	Marshall	Baker	Jr.	2. DATE OF DEATH MONTH D					
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)			November	7 1				
2		220-16-1133	1 M 2 D F	70 YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) OS / 19/ 34	M:	ary land			
2, 3 should	_	9a. FACILITY NAME (If not institution, give			· ·	N OR LOCATION OF DE	EATH	9c. COUNTY (
	RECTOR	Washington County Hospital Hagerstown WASHINGTON										
ges 1,		10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10										
permit. Pages	□	Maryland Was	hington	Н	lagerst				1 YES 2 NO			
ısı	FUNERAL	11 W.Baltimore	S †.			21740			OF WHAT COUNTRY?			
DZO physician. burlal-transit	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS	DECENDENT OF HISPAN , specify Cuban, Mexica	IIC ORIGIN? (Specify Yes	or No- 14. f	RACE — American Indian, Black, White, etc.			
the signal of	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR O	DATES		YES 2 NO Specify			Specify: White			
r attend use as	밀	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	18a. DECEDENT'S (Give kind of	USUAL OCCUP	ATION most of working	16b, KIND OF BU	SINESS/INDUST	RY			
pital or or of for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Drive	work done during se retired.)		Publish	sing Cou	maanu			
he hospit detached once.	NO I	17. FATHER'S NAME (First, Middle, Last)		Dilve	:1	18. MOTHER'S NA	ME (First, Middle, Malden		прапу			
Pe d			rshall	Baker,Sr	•	Mary		,	omer			
retained 5 should notified	O BE	19a. INFORMANT'S NAME (Type/Print)	-				Route Number, City or Tow		p)			
ay be ret page 5 s	2	Goldie M.Hoover		11 W.	Baltim	ore St.Apt	.614 Hager	stown,	MD 21740			
Page 6 may be adirector, page		20a, METHOD OF OISPOSITION 1	noval from State	b. PLACE AND DATE	OF DISPOSITION	(Name of	0ATE 20c. LO 1994 Fred	CATION - CITY O	or Town, State			
		21. SIGNATURE OF TANERAL SERVICE L	DEPOSES A	II.OIIVeI		E ANO ADDRESS OF FA		Jei ick,i	4D 21701			
2 5 E E		>1/1 (g-///	·Ohno				AL HOME Williamsp	ort,MD	21795			
cely filled in by nation, or remoti, the medic.		23. PART I. Effer tha disasses, or ahock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	. List only one cause on a	each line.		mode of dying, such		ratory arrest,	Approximate Interval Between Onset and Death			
and and part	NO	Sequentially list conditions,	bDUE TO (OR AS	A CONSEQUENCE O	P:							
ficate be ophysiclan to prior to	CATION	cause. Enter UNDERLYING CAUSE (Disease or Injury										
	ERTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
e figure	Ä	resulting in death) LAST										
the death the atter Mental	IL C	PART II. Other aignificant condition	na contributing to death	but not resulting	in the undari	ying cause givan in	Part J. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS			
that the dea the by the at th and Menta	DICAL	Dementia	phoun	nohia	1 F	actives	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
law requires as been sign lept. of Heat	ME	put hip	, , , ,						OF DEATH? 1 YES 2 NO			
law re as bee Dept. o		DID TOBACCO USE	CONTRIBUTE TO	CAUSE O	F DEATH	YES NO						
a at a E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	PLACE OF DEATH (Ch						
PHYSICIAN: this certifica with the St rked, or It	HYS	1 YES 2 NO 27. MANNER OF DEATH	1 in Inpatient 2 I ER/Out	patient 3 DOA		INJURY AT	8 Other (Specify) 28d, DESCRIBE NOW I	N HISV GCCHRE	0			
子 等 章	ву Р	1 Netural 5 Pending 2 Accident Investigation	11128	94 04	95 1	WORK? YES 2 AO	Goto	tot.	bed-fell			
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	ED	3 Suicide 8 Could not be determined	28e. PLÄCE OF INJUR building, etc. (Spe	Y — At home, ferm,	street, factory, o	ffice for	28f. LOCATION (Street of City or Town, State)	and Number or Ru	iral Route Number,			
OR AI DIREC hours	Ē	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the beat of my know	winden death occur	ard at the time	two and place and due	c //cy	27.7	ecol V 12			
로 보고 본	COMP	(Check only one) 2 MEDICAL SHOUMIN							use(a) and manner as stated.			
물물물	BE	296. SIGNATURE AND TITLE OF CERES				29c PICENSE NUM	ABER COG	294. DATE SIG	1164			
5 5 3 X	5	30. NAME AND ADDRESS OF PERSON W	HO SHIP LIFED CAUSE OF DE	EATH (ITEM 27) (Type	, Print)	16- 1	1. 4	-/-	2/1/2			
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	14//	1014	ION N	4 79	CNY	LMM			
		DEC 0 2 1901	£						21742			
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_	ours	ui pa	0r re	med
	2	ly fill	ation,	the
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 is	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner mur
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	10	5	8	IMP M

			1. DECEDENT'S NAME (First, Middle, Last)	
			James Alfred BAII	EY
			4. SOCIAL SECURITY NUMBER	5. SE
			212-24-5356	1 <u>K</u>
hould			9e. FACILITY NAME (If not institution, give st	reet an
en S		OR	Washington County	и Не
1.2		5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	_
Pages		H		
H.		٥١	Maryland Washi	ng
020 physician. burial-transit permit. Pages 1, 2, 3 should		BY FUNERAL DIRECTOR	440 Jefferson Str	*00
ian. trans		NE NE	11. MARITAL STATUS	12. V
120 Mriaj		교	1 Never Merried 2 Married	F
Jing p		BY	3 Widowed 4 Divorced	IF
10 5 8		TO BE COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION
21. For u			Elamentary/Secondary (0-12)	Coll
Nospit ched	ಷ	MP	11	
the h	once.	\bar{g}	17. FATHER'S NAME (First, Middle, Last)	
d by	d at	36	George	
TAP staine	otifie	0	19a. INFORMANT'S NAME (Type/Print)	
be r	e no		Betty C. Bailey	
may or. pa	ust b	å	20e. METHOD OF DISPOSITION 1. Burial 2 Cremetion 3 Remo	ovat fr
MC age 6 direct	E		4 Donetion 5 Other (Specify)	
th. P.	mine		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE
BALTIMORE, er death. Page 6 may be the funeral director, page	exa		2000/	//
ECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 2121 BALTIMORE, MARYLAND 2121 BALTIMORE STATEMENT OF STATEMENT	or hearn and Mental Hygiene prior to burial, cremation, or removal. shows any Injury, or other traumatic event, the medical examiner must be notified at		23. PART I. Entar tha diseases, Dr c	
our led in	me		ahock, or haart fallure. (IMMEDIATE CAUSE (Final	LIST O
Ely fill	the		disease or condition	·N
with mplet	vent		resulting in death)	
cuted d cor	ite e	z		h.
X C	ema	일	Sequantially list conditions, if any, laeding to immediate	
ate by Sicis	r tra	8	cause. Enter UNDERLYING CAUSE (Disease or injury	C
ordific.	othe	E	that initiated eventa	
tendir	0.0	ᇤ	resulting in death) LAST	J
(ECOMDS, P.O. BOX 68760, equires that the death certificate be executed within an signed by the attending physician and complete	jury,	MEDICAL CERTIFICATION	PART ii. Other significant conditions	s con
Tat the	and ty in	S		
res the C	earth FS 31			
Tequi	show		DID TOBACCO USE	
	23 c	PHYSICIAN:		CON
The	tem	2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HO!
TENDING PHYSICIAN: The law	Is marked, or item 23	IYS	1 TYES 2 NO	1 ()()
PHYS! C	Ked,	F	27. MANNER OF DEATH 1 Netural 5 Pending	
Ing P	mar	ВУ	2 Accident Investigation	-
PENDI OF	28 Is		3 Suicide 8 Could not be 4 Homtcide determined	
- E E,	2 2	Ē		

	1 - FOR STATE OF MARYLANI	D / DEPARTME CERTIFICA			MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	- Ab-	3. TIME OF DEATH
	James Alfred BAILEY				December	3 1994	9:17 M
		//	-	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. BIR	THPLACE (State or Foreign
	212-24-5356 1X M 2 🗆 F 61	YRS. MONT	HE DAYS I	HOURS MIN.	Jan.6, 193		aryland
_	9e. FACILITY NAME (If not institution, give street and number)	9b. (CITY, TOWN OR	LOCATION OF DE		9c. COUNTY OF	DEATH
5	Washington County Hospital		Hager	stown		Washir	ngton
EG	10e. STATE 10b. COUNTY	10c. CITY, TOY	WN OR LOCATIO	ON .			10d. INSIDE CITY
DIRECTOR	Maryland Washington	Hage	rstown				LIMITS?
	10s. STREET AND NUMBER		_	TIP CODE		10g. CITIZEN OI	F WHAT COUNTRY?
FUNERAL	440 Jefferson Street			21740		US	SA.
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2				C ORIGIN? (Specify Yes	or No.— 14. RA	CE — American Indian, ack, White, etc.
ВУ	1 Never Merried 2 Married FORCES 7 1- YES 2 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES		1 TYES 2		, Pueño Ricen, etc.)	Sp	ecify:
		D. DECEDENT'S USUA	1 00010171011				ite
	(Specify only highest grade completed)	(Give kind of work di life. Do NOT use retin	one during most	of working	16b. KIND OF BUS	olasting	
<u>a</u>	Elamentary/Secondary (0-12) College (1-4 or 5 +)	assemb1	_			ncturing	-
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAM	E (First, Middle, Maiden		
BE C	George Bailey			Cynthi	a	Mond	le11
2	19a. INFORMANT'S NAME (Type/Print)				oute Number, City or Town		
-	Betty C. Bailey	440 Jef	ferson	St., Ha	gerstown,	Marylar	nd 21740
á	20e. METHOD OF DISPOSITION 1.X Burial 2 Cremetion 3 Removat from State 20b. PLA cemelery	ACE AND DATE OF DIS	POSITION (Name	e of	DATE 20c. LOC	CATION — City or	Town, State
	4 Donetton 5 Other (Specify) ROS 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	se Hill C	emeter	y 12-6-	94 Hage	erstown,	Maryland
		/	MINNIC	H FUNERA	Т номе		
	Scott///unne	-					n, Md. 21740
- 1	23. PART I. Enter the diseases, Dr complications that caused the ahock, or heart fallure. List only one cause on each	a daath. Do not ar iina.	nter tha mode	a of dylng, such	as cardiac or respin	ratDry arrest,	Approximata Intarvai Between
	IMMEDIATE CAUSE (Final disease or condition			10 - 0	0 0		Oneat and Death
	resulting in death) a. Metastout DUE TO (OR AS A COI	ichen	- 5 me	all Cel	lung	cance	1 4 month
	DUE TO (OR AS A CO	NSEQUENCE OF):			J		,-
Ó	Sequentially list conditions, if any, leading to immediate	NSEQUENCE OF):					
S	cause. Enter UNDERLYING CAUSE (Disease pr injury						
E	that initiated eventa DUE TO (OR AS A COR	NSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST						
AL C	PART II. Other significant conditions contributing to death but n	ot resulting in the	underlying (cause givan in F	Part I. 24s. WAS AN		4b. WERE AUTOPSY FINDINGS
					PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEC						74.0	DF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CA	AUSE OF D	EATH YE	S NO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:			CE OF DEATH (Che	ck only one)		
YSI	1 YES 2 NO 1 Inpatient 2 ER/Outpatien		HER: Nursing Home	5 Residence	Other (Specify)		
표	27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJUR	(?	26d. DESCRIBE HOW IN	JURY OCCURED	
ВҰ	2 Accident Investigation			S 2 NO			
	3 Suicide 8 Could not be 4 Homicide determined	it home, farm, streat,	tactory, offica		26t. LOCATION (Street a City or Town, Stete)	nd Number or Run	il Route Number,
COMPLETED	29a. CERTIFIER						
MP	(Check only CERTIFYING PHYSICIAN: To the best of my knowledge						
0	2 MEDICAL EXAMINER: On the basis of exemination and	a/or investigation, in i	my opinion, dea	nn occured at the t	ime, data and place, end	due to the ceus	e(e) end menner ee stated.
Ο∥	COL CICULATION AND VITE OF COMPANIES A		-				
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		n 1	29c. LICENSE NUM	BER / 7 >	29d. DATE SIGN	ED (Month, Day, Year)
	Hand Horand	(ITEM 27) (Turns Print)	n	D 46 4	73	≥ A /	ED (Month, Day, Year) 4 / 9 L 1
BE	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	$\alpha I = I$	n	D 464	H73	29d. DATE SIGNI	ED (Month, Day, Year) 4 / 9 L 1
BE	Hand Horand	.Clevel.	nn!	D 464 AVE	+73 Hag. 1	nd 2	ED (Month, Day, Year) 4/941 1740

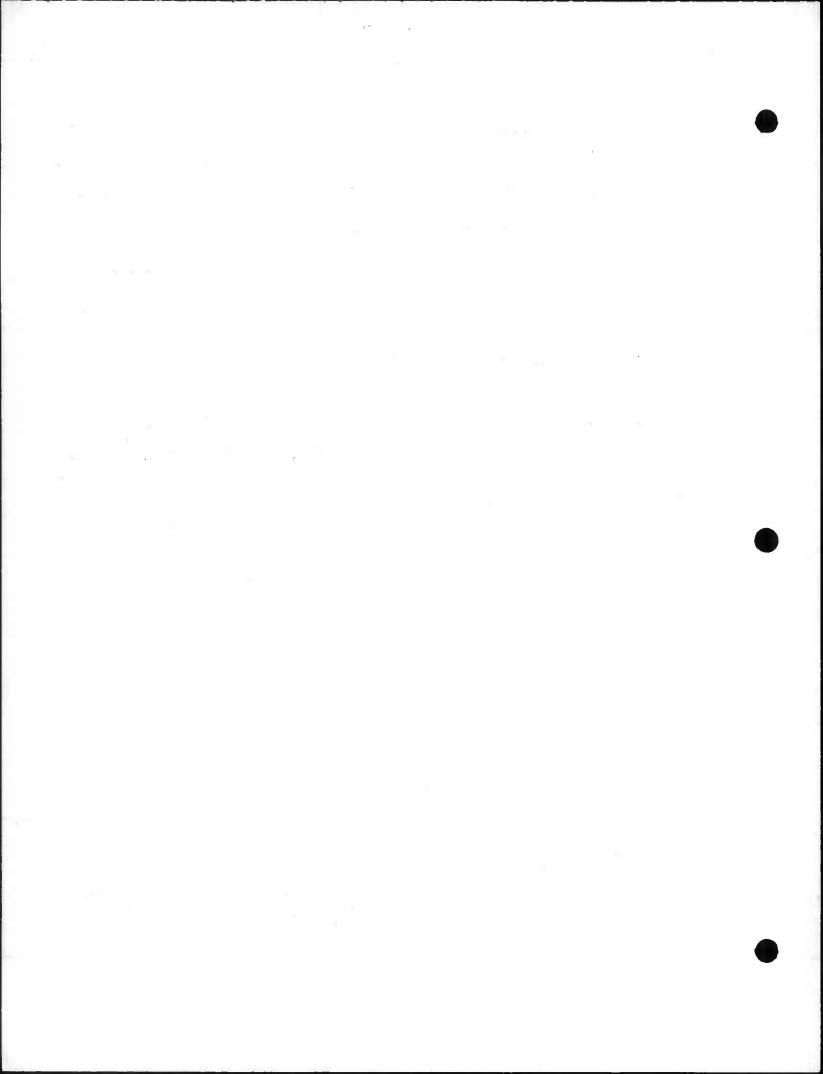


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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after deal	y the fun	moval.	Pal ava
hours after death. Page 6 may be ret	lled in bi	n, or ren	madi
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ite be ex	ding physician and comp	prior to	Separate
certifica	iding phi	Hygiene	Tother a
he death	the atter	Mental	ninov n
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AN: The law requires that the death certif	been si	of He	2 chour
I: The la	cate has	State Dept. of	Ham 2
3	200	do.	ad ha
DING PH	After th	death w	o mark
R ATTEN	RECTOR	urs after	J 90 m
PITAL DI	ERAL DIS	n 72 hou	T. 16 100
) THE HOSPITAL DR ATTENDING PHYSI	THE FUNERAL DIRECTOR: After this	e filed within 72 hours after death with the	UDOTANT: if item 22 is marked or item 22 shows any injury or other fraumotic event the marked eventues he marked at once
0 1	0.1	e i	G T

	1 - FOR STATE REGISTRAR	STATE OF MARY				HEALTH AND	MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH		VE. 1	3. TIME OF D	EATH
-		Compton		BU	RGESS		NC	.22 °	1994	YEAR	6:00	Рм
- 8	FEO 00 0101		E (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH th, Day, Year)	T	. BIRTH	PLACE (State or	Foreign
			31	YRS.	DATE	noons win.	July	5,196	3 1	-	ningtor	n DC
DIRECTOR	98. FACILITY NAME (If not institution, give stree CAMP SPRINGS PA RESIDENCE OF DECEMENT					OR LOCATION OF D			9c. COUNT		E GEOR	GES
EG	10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE C	ITY
		George's		F		hington					LIMITS?	XNO
FUNERAL	100. STREET AND NUMBER 8838 Oak Lane				.10	20744			U.S.		WHAT COUNTRY	"?
3	11. MARITAL STATUS 12	. WAS DECEDENT EVER			13. WAS DE	CENDENT OF HISPA	NIC ORIGI	N? (Specify Yes		4. RACE	- American Ir	ndlen,
BY F	1 Never Married 2 Married	FORCES? 1 YE		10		pecify Cuban, Maxic S 25 NO Speci		Rican, atc.)		Black Specific	c, White, atc.	·
	3 Widowed 4 Divorced				1	21				Cauc	casian	
ËΙ	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION npleted)	(Gi	ive kind of wo	SUAL OCCUPAT rk done during m		166	b. KIND OF BUS	INESS/INDU	STRY		
COMPLETED	Elementary/Secondary (0-12) (N/A	1	lectr				Burgess	~ Ente	`````	ri ana	
NO	17. FATHER'S NAME (First, Middle, Last)			20002	10101	18. MOTHER'S NA				STOT	ises	
	Compton Benjam	in Buro	ress			4.1	rlee		ouise	2	Mabry	
BE	19a. INFORMANT'S NAME (Type/Print)			. MAILING A	DDRESS (Street	and Number or Rural					TRIOLY	
임	Compton B. Burges	s		580	4 Aley	Road Ca	mp S	prings	Md. 2	2074	18	
	20s. METHOD OF DISPOSITION 1 ☐ Burlel 2 💢 Cremetton 3 ☐ Ramova	I from State	Ob. PLACE	AND DATE OF	DISPOSITION (A	ame of	DAT	TE 20c. LOC	CATION — CI			
	4 Donation 5 Other (Specify)		Lee	matory or other		Nov. 24,			lintor	1, M	iarylan	d
	21. SIGNATURE OF FUNERAL SERVICE LICEN				22. NAME A	ND ADDRESS OF FA	ACILITY_	ee Fune	eral H	Iome	, Inc.	
	Charles L.	Belon	1	/		Old Ale		20	777		inton,	Md
	23. PART i. Entar the diseases, or con shock, or heart failure. Lis iMMEDIATE CAUSE (Final disease or condition reaulting in death)	Hang	aach ilna		t enter tha m	ode of dying, suc	ch as car	diac or respi	relory stres	et,		mate Between and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL (PART II. Other significant conditions of	ontributing to death	but not ra	asuiting in	tha undarlyir	g cause given in	Part i.	24s. WAS AN PERFORM	MED?	24b.	WERE AUTOPSY AMAILABLE PRIE COMPLETION D OF DEATH?	OR TO F CAUSE
ż	DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEA	TH YES	□ NO \$	⊉ UNCERTAI	N 🗆					
당	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLAC		(Check only one							
XS!	TX YES 2 NO 1	☐ Inpetient 2 ☐ ER/O				ne 5 🗆 Raaidenca	6X Oth	or (Specify) S	CENE			
표	27. MANNER OF DEATH 1 Netural 5 Pending	28s. DATE OF INJURY		28b. TIMB	RY W	JURY AT ORK?	26d. DE	SCRIBE HOW IN	JURY OCCU	RED	2011	
B	2 Accident Investigation	28s. PLACE OF INJU	-94	1900		YES 2 NO	300	,cor	hang		ser	
	3 Sulcide a Could not be datarmined	building, stc. (S)	pecify)	rrian, imeriti, mile	set, tactory, om		City	CATION (Street a	nd Number or	r Rural A	01	
9	29a. CERTIFIER						La	17	DIING		PO(.	
COMPLET	(Check only one) 2 MEDICAL EXAMINER: (N: To the best of my knoon the bests of examinet) and manner a	stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	6/0/1				29c. LICENSE NU	MBER		29d. DATE S	SIGNED	(Month, Day, Yes	nr)
<u></u>		8 al				0.C.I	м.Е.		NO	V.2	3,199	4
ا "	30. NAME AND ADDRESS OF PERSON WHO C	- ler	111	Pen		eet, Ba	ltim	ore,	Mary.	lan	d 212	01
	31. DATE FILED (Month, Day, Year) 1994	JULA DAVE	LIAN-RO	relate.		-						



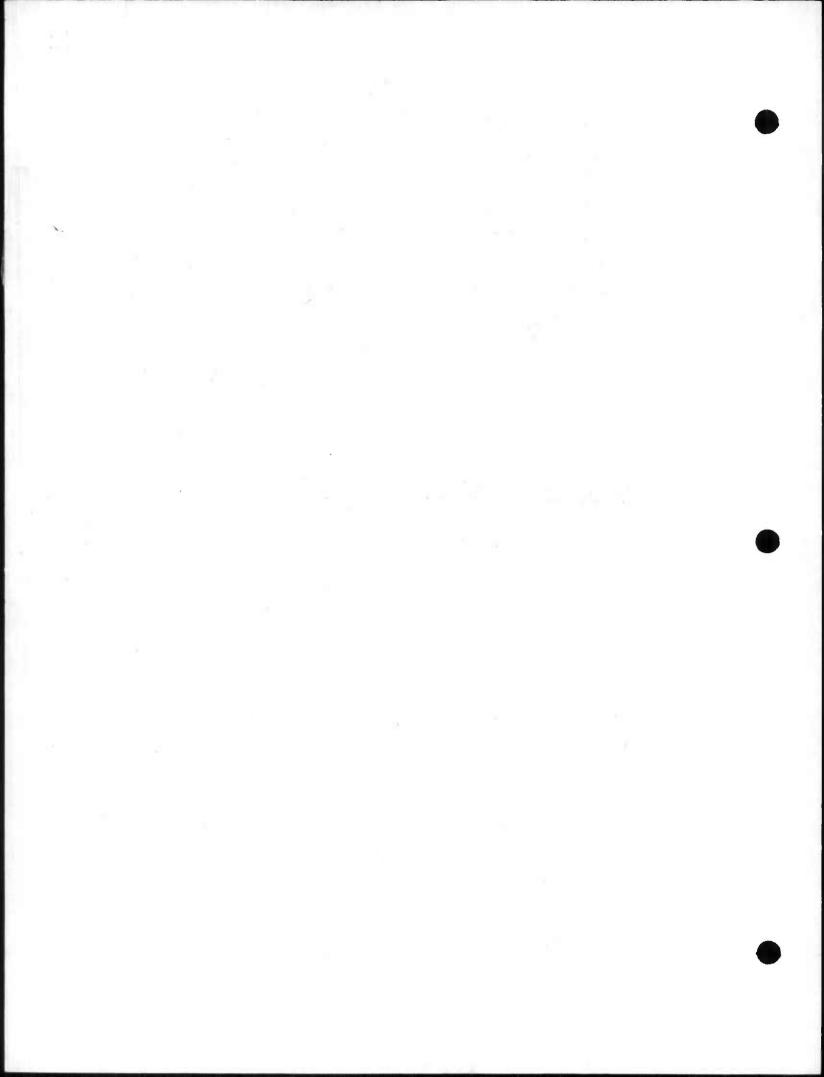
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with now and the feath of the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTA	L HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest) WALTER KAUFMAN (CONNELLY	_			MONT	OF DEATH		EAR	TIME OF DEATH 10:15 P M
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	UNDER T YEAR	IF UNDER 24 HRS.		OF BIRTH	199	BIRTHPL	ACE (State or Foreign
	214 - 38-2262	1 M 2 🗆 F	54 YRS.	ONTHS DAYS	HOURS MIN.	Aug.	9, 19		Country) Mary	
~	9e. FACILITY NAME (If not institution, give st				R LOCATION OF DE	EATH		9c. COUNTY		
DIRECTOR	Stella Maris	Hospice		Timoniu	ım			Bal	timo	re
E	10e. STATE 10b. COUNTY	1	10c. CITY, T	OWN OR LOCAT	ION				10	d. INSIDE CITY LIMITS?
	Maryland	Baltimore		Randa	11stown				1	YES 2 NO
A	10e. STREET AND NUMBER			101	ZIP CODE			10g. CITIZE	N OF WHA	T COUNTRY?
FUNERAL		adow Heights			21133			Unit	ed St	ates
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YE'S IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPAR ecify Cuban, Maxica 2 NO Specifi	n, Puerto I		or No- 14	Specify:	American indian, hite, etc. White
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18e. DECEDENT'S US (Give kind of work	done during mo	N st of working	166	. KIND OF BUS	INESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use re			,	umb oss	Commo	~**	
Š	17. FATHER'S NAME (First, Middle, Last)		Account	LING			umber		ПУ	
BE CO		Edward	connel:	ly	16. MOTHER'S NA E1	nora.			offma	an
0	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural				-	
-	David c. Connell				Ct./ Fre	ederi			1705	
	20e. METHOD OF DISPOSITION 1		PLACE AND DATE OF COMMENT OF COMM			ns 12		Fred		
ĺ	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AN	D ADDRESS OF FA	CILITY S	tauffa	r Fun	ora1	Home
\$	(Damend)	9/								1d. 21702
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	e. Panaradu DUE TO (OR AS A DUE TO (OR AS A	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF):	enter the mo	de of dylng, suc	h as cerd	liac or respli	atory arres	ξ,	Approximate Interval Between Onset and Death 3 weeks 3 weeks
H	resulting in death) LAST	d								
MEDICAL	PART II. Other eignificent condition				PERFORMED? 1 □ YES 2 0 N NO				AM CO OF	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
A P	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL	COMIKIBUTE TO	CAUSE OF I		ES NO					
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outy	reflect 2 🗆 DOA	THER	5 Residence	**		IOCDIO	I D	
Ĕ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O	_			CRIBE HOW IN	HOSPIC		
	1 Natural 5 Pending investigation	(Month, Day, Year)	INJUR	Y WO 1 □ 1	RK?					
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	— At home, farm, stre	et, factory, office		28f. LOC City	ATION (Street a or Town, State)	nd Number or	Rural Rout	Number,	
COMPLETED	onel	CIAN: To the best of my know								d menner ee stated.
	296 SIGNATURE AND TITLE OF CERTIFIER	Fauler	ems		29c. LICENSE NUI	MBER 43		29d. DATE S	IGNED (M	onth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	int)						
	DR. KENDALL FAULK		JLANEY VAL	LEY RD	TOWSO	N, MI	2120)4		
	DEC 1 2 1994	32. REGISTRARYS SIGN	har Randall							



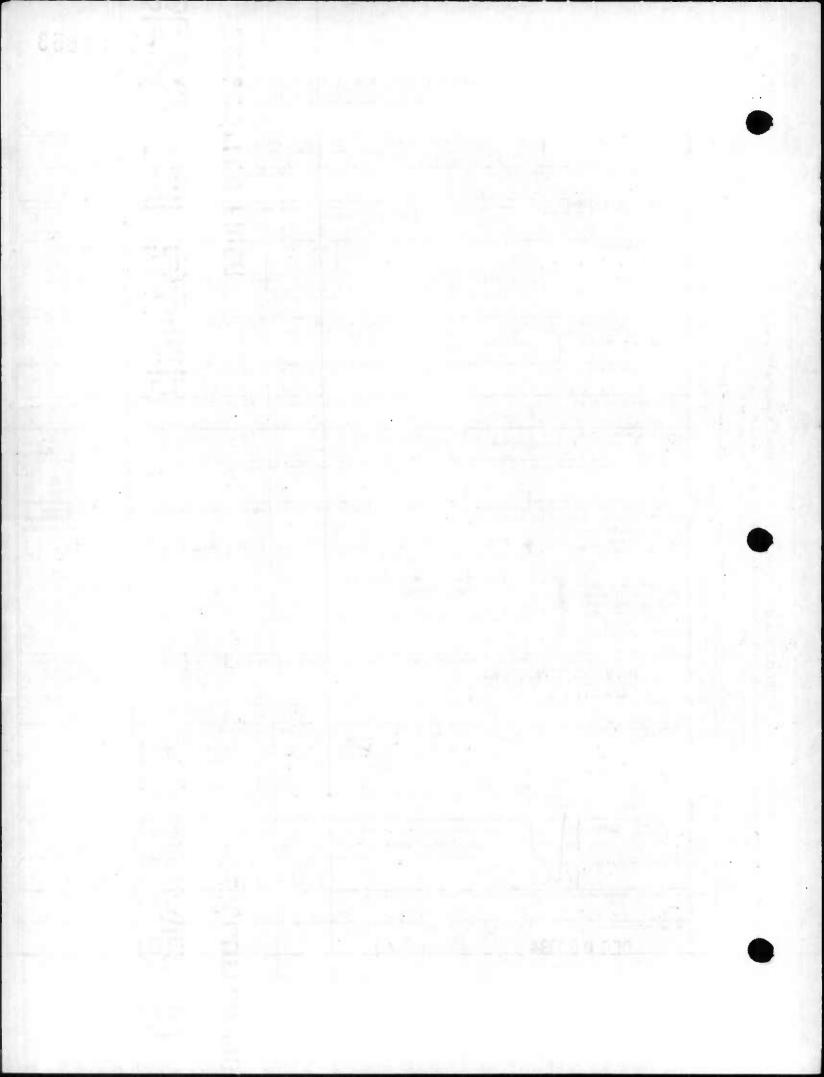
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DIVISION OF VITAL R

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should YLAND 21215-0020

	1. DECEDENT'S NAME (First, Middle, Last	1)	OLI	THICA	IE OF	DEATH	2 DATE	REG. NO.			3. TIME OF DEATH
		JEAN	CAIN				Nove	ember 3	30, 19	94	3:10
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last bi	MONT	IDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	of BIRTH	1021	B. BIRTH	PLACE (State or Foreign)
	579-28-4863 9a. FACILITY NAME (If not institution, give	1 M 2 F	71	YRS.	TTY TOWN O	R LOCATION OF	_	n. 15,	1923		
CTOR	Meridian Nursing Center Frederick Frederick										
בֿן װ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	ity		10c. CITY. TOW	AL OR LOCAT	ION					44 4 101010 01714
DIRE		derick			derick						10d. INSIDE CITY LIMITS? 1 YES 2 X NO
AL	10e, STREET AND NUMBER				101.	ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
NEB	4813 Reels Mill						United States				
BY FUNI	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. ARME 1 YES 2 NO WAR OR DATES		If yes, spe	ENDENT OF HISP Holfy Cuban, Mexi 2 NO Spe	ican, Puerto		or No-	14. RACE Black Specia	- American Indian, , Whila, atc. y: White
6	15. DECEDENT'S ED (Specify only highest gra-	DUCATION de completed)	16a. DECE	DENT'S USUAL	L OCCUPATIO	IN st of working	16	b. KIND OF BUS	SINESS/INDU	STRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	kind of work do	id.)	a or Normany		0	7.		
COMPL	17. FATHER'S NAME (First, Middle, Last)	- 4	Tome	emaker		18. MOTHER'S	NAME (First.	OWI Middle, Maiden		-	
BEC	Harry E. Steff	ey					neva	Johnso			
0	19a. INFORMANT'S NAME (Type/Print)	3/1.2				nd Number or Run					170:
	George Donald Ca	iin	20b. PLACE AND			11 Road		rederio			1701
	1 Burial 2 Cremation 3 Ra 4 Donation 5 Other (Specify)	moval from Stata	cemetery, creme	tory or other pla LINCOLI	n Ceme	etery					Marylan
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	0				-				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P 1621 Opossumtown Pike Frederick, MD 2170										
	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Aw	te ner	Do not en	iter the mo	de of dying, s	uch aa car	diac or respi	ratory arre		Approximate intervel Betv
ATION	immediate Cause (Final disease or condition	a. Au	te Rep	Do not en	ou'l u	de of dying, s	uch aa car	diac or respi	ratory arre		Approximate intervel Betv
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate	a. Due To	te Rep O (OR AS A CONSEQUE OTE S	Do not en	ou'l u	de of dying, s	uch aa car	diac or respi	ratory arre		Approximate intervel Betv
AL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentiely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO b. DUE TO c. DUE TO d	Te Reconsecution of the Consecution o not en	outer the model of the country of th	de of dying, so	vch aa car	diac or respi	AUTOPSY	at,	Approximate Intervel Bett Onset and D	
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PHYSICIAN: MEDICAL	Shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST PART II. Other significent conditions HAPPENT ORSETT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	a. DUE TO b. DUE TO c. DUE TO d. Ons contributing to PNS1SN HOSPITAL: 1 Inpatient 2 2sa. DATE Of (Month, L.)	Te Recovery of the Aconseous of the Acon	ENCE OF): ENCE OF): Ulting in the	underlying 28. PL 128. INJIN HOME 28. PL 28. PL 28. PL WO 28. INJIN HOME 28. INJIN HOME 28. INJIN HOME 28. INJIN HOME WO	de of dying, so	In Part i.	24a. WAS AN PENFOR	AUTOPSY MED?	246.	Approximate Intervel Betwonset and D
ED BY PHYSICIAN: MEDICAL	SHOCK, Of heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other aignificent condition 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 1 Investigation 3 Suicide 5 Could not be 4 Homicide	a. DUE TO b. DUE TO c. DUE TO d. HOSPITAL: 1 Inputent 2 29a. DATE Of (Month, E) 26a. PLACE OF	O (OR AS A CONSEQUED O COR AS	ENCE OF): Ulting in the DOA OTH DOA OTH DOA OTH JURY N	underlying 26. PL AES: Nursing Hom 26. INJI WO 1 □ Y	de of dying, so	In Part I.	24a. WAS AN PENFOR 1 DIVES 2	AUTOPSY IMED?	24b.	Approximate intervel Bets Onset and D 4 da 4 da 4 da 4 da 4 da 4 da 4 da 4
ED BY PHYSICIAN: MEDICAL	SHOCK, Of heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST PART II. Other algnificent condition HAPPENT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Return 5 Pending 1 Investigation 2 Accident 3 Suicide 5 Could not be datermined 29a. CERTIFIER (Check only) 2 MEDICAL EXAMIN	a. DUE TO b. DUE TO c. DUE TO d. Ons contributing to PNSIS N HOSPITAL: 1 Dispatient 2 28a. DATE Of (Month, I) 28a. PLACE (building)	COR AS A CONSEQUENCE OF CORRECTION OF CONSEQUENCE OF CORRECTION OF CORRE	ENCE OF): ENCE OF): ENCE OF): Ulting in the DOA OTH DOA 4 D 23b. Time OF INJURY N of farm, street,	underlying 26. PL 1EB: Mursing Hom 28c. INJI 4 1 V 4 factory, office	de of dying, set	In Part I. Check only of 26d, DE 281, LOCChy	24e. WAS AN PENFOR 1 DIES 2	AUTOPSY MED? NJURY OCCU	24b.	Approximate intervel Betwonset and D 4 da 4 da 4 da 4 da 4 da 4 da 4 da 4
BE COMPLETED BY PHYSICIAN: MEDICAL	SHOCK, Of heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificent condition HAPPENT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 1 Investigation 3 Suicide 5 Could not b data mined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFI	a. DUE TO b. DUE TO c. DUE TO d. Ons contributing to PNSIS N HOSPITAL: 1 Inpatient 2 25a. DATE Of (Month, I) 25a. PLACE (building)	O (OR AS A CONSEQUENT OF INJURY Day, Year) OF INJURY — Al home, atc. (Specify) of my knowledge, death examination and/or inwested	ENCE OF): Ulting in the DOA OTHER OF INJURY To courred at the eatigation, in a	underlying 26. PL 1EB: Mursing Hom 28c. INJI 4 1 V 4 factory, office	de of dying, set	in Part i. Check only c a 6 Oth 25d. DE 26f. LO	24e. WAS AN PENFOR 1 DIES 2	AUTOPSY IMED? NO NO NO NO NO NO NO NO NO NO NO NO NO	24b. JRED d. cause(a	Approximate intervel Betwonset and D 4 day WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAU DF DEATH? 1 YES 2 No
E COMPLETED BY PHYSICIAN: MEDICAL	SHOCK, Of heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST PART II. Other algnificent condition HAPPENT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Return 5 Pending 1 Investigation 2 Accident 3 Suicide 5 Could not be datermined 29a. CERTIFIER (Check only) 2 MEDICAL EXAMIN	a. DUE TO b. DUE TO c. DUE TO d. DUE TO d. DUE TO 28a. DATE Of Month, 1 28a. DATE Of building. THICIAN TO the best of MER on the best of a	D (OR AS A CONSEQUENT OF INJURY — Al home of my knowledge, death axamination and/or invitation of the consequent of the	ENCE OF): Ulting in the DOA OTHER OF INJURY To courred at the eatigation, in a	26. PL LEB: Mursing Hom 28c. INJI WO 1 V factory, office	ACE OF DEATH (5 Rasidence URY AT RICY and place, and deseth occured at 1	in Part I. Check only of a 6 Oth 25d. DE 25f. LO. Cir. Cir. Cir. Cir. Cir. Cir. Cir. Cir	24a. WAS AN PERFORM 1 (Specify) SCRIBE HOW III CATION (Street a or Town, State)	AUTOPSY IMEE? IN NO NJURY OCCU and Number of the dua to the 29d, DATE 29d, DATE	24b. JRED d. cause(a	Approximate Intervel Bets Onset and D 4 da 4 da 4 da 4 da 4 da 4 da 4 da 4



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flows after death. Page 6 may be retained by the brospital or attending physician.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

219-07-3073 1	1 - FOR STATE REGISTRAR	OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND I	WENTAL HYGIENE REG. NO.	
219-07-3073 1	G	racie Coulter			YEAR
GALVERT MAINT NO. CREATERS. No. STATE THOM SOUTH STATE STAT	219-07-3073 1□ м 2 5	3kF 95 YRS. ™	NTHS DAYS HOURS MIN.	May 2 1899	West VA
190. STEET AND NAMED 1790 RISKING SUR Rd 2917 100 100 COUNTY 100 100 COUNTY 100 NAME 11. MARTAL STATUS 12. MARTAL STATUS 13. MATTAL STATUS 14. DECEMBER STATUS MARTAL STATUS M	Calvert Manor Nursing				
## 10 Protect of Discovery Control of Disco	MD Cecil				LIMITS?
## SECREPATE SEC				10g. C	
The intrinsical events of plant intrinsical events of plan	1 Never Married 2 Married FORCES	? 1 ☐ YES 2 ☐NO	If yes, specify Cuben, Mexica	n, Puerto Rican, etc.)	Black, White, atc.
Sequentially liet conditions and service conditions contributing to death but not resulting in the underlying course given in Part I. Sequentially liet conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial conditions contributing to death but not resulting in the underlying course given in Part I. Comercial c	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give kind of work life. Do NOT use n	done during most of working stired.)		NDUSTRY
George A. Coulter 30 Coulter Lane Colora MD 21917 20. METHOD OF DISPOSITION Signature DATE 20. LOCATION — City or Town, Statis Country or Control Control	Andrew J Ware	JOD MAILING AD	Vinora	Coberly	
1 General 2 Cremention 3 Removed term Blake 4 Denation 8 Other (Second) Unionville PA	George A. Coulter	30 Cou	lter Lane Color	a MD 21917	
2 Accident 3 Suicide 4 Homicide 28a. PLACE OF INJURY — At home, farm, street, factory, office 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CHILIFER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	23. PART I. Entar the diseases, or complication shock, or heart failure. List only or immediate cause. (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other algorificant conditions contributions.	UE TO (OR AS A CONSEQUENCE OF): UE TO (OR AS A CONSEQUENCE OF): UE TO (OR AS A CONSEQUENCE OF):	R T Foard Fund 111 S Queen St enter the mode of dying, suc	Part I. 24a. WAS AN AUTOPS PERFORMED?	Y 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
2 Accident 3 Suicide 4 Homicide 28a. PLACE OF INJURY — At home, farm, street, factory, office 4 Homicide 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFER 29c. SIGNATURE AND TITLE OF CERTIFER 30. NAME AND ADDRESS OF PERSON WITO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE			26. PLACE OF DEATH (Ch	eck only one)	1 TYES 2 NO
2 Accident 3 Suicide 4 Homicide 28a. PLACE OF INJURY — At home, farm, street, factory, office 4 Homicide 28a. PLACE OF INJURY — At home, farm, street, factory, office 28a. PLACE OF INJURY — At home, farm, street, factory, office 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28c. CERTIFIER (Check only orie) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	1 VES 2 NO 1 Inpetier	nt 2 - ER/Outpatient 3 - DOA 4	Nursing Home 5 - Residence		
(Check only One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CHITIFER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF DEATN (ITEM 2D) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	onth, Day, Year) INJUR' ACE OF INJURY — At home, ferm, stre-	WORK? M 1 YES 2 NO	281. LOCATION (Street and Numb	
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF DEATN (ITEM 22) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	(Check only one) 2 MEDICAL EXAMINER: On the bas			time, date and place, and due to	the cause(a) and manner as stated.
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	Mul R talas	D CAUSE OF DEATN (ITEM, 27) (Type, Pri	D-1111	ABER 29d. D	ATE SIGNED (Month, Day, Year)
	31. DATE FILED (Month, Day, Year) 32. REC	MAD KIS	ing Sm, N	18	

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BALTIMORE, MARYLAND 21215-0020	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physic	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
58760,	cuted within	d completely fill purial, cremation
O. BOX (ertificate be exe	ng physician an giene prior to t
ORDS, P.	hat the death c	d by the attendi
AL RECO	e law requires	has been signe Dept. of Health
OF VIT	PHYSICIAN: Th	this certificate with the State
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the it hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal.

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CERTIFICATION

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this certificate has been signed with the State Dept. of Health THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires L DIRECTOR: After the 2 hours after death w TO THE HOSPITAL TO THE FUNERAL DE BIEd within 72 h

FOR STATE REGISTRAR	STATE OF I	MARYLAND / CE	DEPAR						GIENE
DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEA	
Walter B. Carol	Lin							Novembe	er 2
SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	1 24 HRS.	7. DATE OF BIRTH	
154-09-4398	MONTHS DAVE HOUSE					HOURS	MIN.	May 6,	
n. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE								EATH	
131 University Bl	Lvd, West	, Apt. 1	1905	Sil	ver	Spr	ing		
ESIDENCE OF DECEDENT									
a. STATE 10b. COUNTY			10c. CITY	TY, TOWN OR LOCATION					
Maryland Montg	gomery		Sil	ver	Spr	ing			
e. STREET AND NUMBER					101	. ZIP COD	E		
1131 University H	Blvd, Wes	st, Apt.	1905			2090	2		
MARITAL STATUS Wildowed A Divorced	FORCES? 1	IT EVER IN U.S. ARI I X YES 2 ☐ N MAR OR DATES	WED O	- 1	f yes, sp			NIC ORIGIN? (Specian, Puarto Rican, el y:	

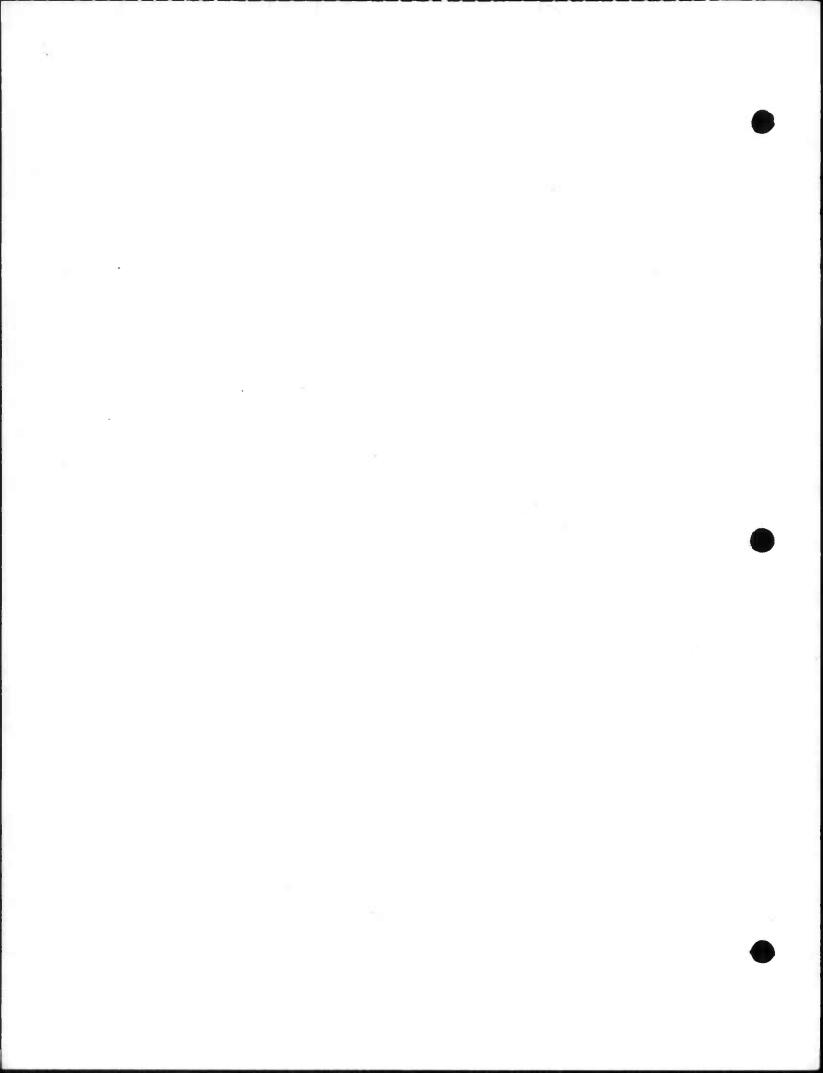
2. DATE OF DEATH 3. TIME OF DEATH 27, 1994 November 5:15 P M 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign May 6, 1919 New Jersey F DEATH 9c. COUNTY OF DEATH Montgomery В 10 10d. INSIDE CITY 1 YES 2 X NO 10 10g. CITIZEN OF WHAT COUNTRY? United States 11 SPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian. Black, White, atc. 1] pecify: 3 White 18a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) 12 Purchasing Agent Union Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable Anna Unobtainable 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) John M. Seifert 6860 Riverdale Road, Apt.101, Lanham, MD 20706 20a, METHOD OF DISPOSITION
1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Arlington Cemetery 4 Donation 5 Other (Specify) 12/5 Kearny, New Jersey 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heert feliure. Liet pniy one ceuee on each ilne. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition i nourt PULLUDONBUR FAILUNN resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 3 nouron CANCEN DELLARUNG Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause, Enter UNDERLYING
CAUSE (Disease or injury CANCEL OF DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other eignificent conditions contributing to deeth but not recuiting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 THO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 5 Pending Investigation м 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 29a. CERTIFIER 1
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurad at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 017368 11 haler 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1994

S.S. MD. 20902 2101 MEDICAL PARK DR.

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Julia Davidson-Randale



DIRECTOR: ,

31. DATE FILED (Month, Day, Year)

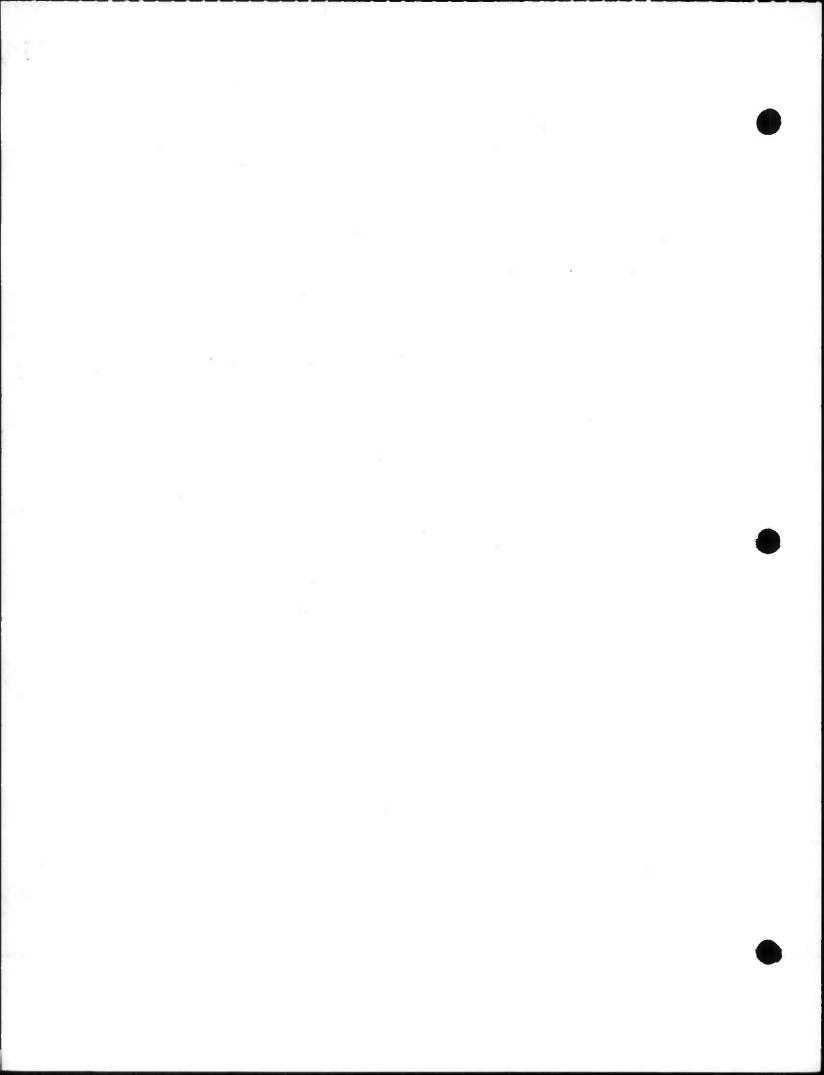
BALTIMORE, MARTLAND 21215-0020	DING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should death with the State Dept, of Health and Memai Hygiene prior to bunial, cremation, or removal.	
ON OF VITAL RECORDS, P.O. BOA 80780.	DING PHYSICIAN: The law requires that the death certificate be executed within 24 h	After this certificate has been signed by the attending physician and completely filled in by the death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	manufacture and the same figures are the same and the sam

12/6/94 MRT Montgome FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) Bern LCP 2. DATE OF DEATH 3. TIME OF DEATH Helen rden 1601 a 4. SOCIAL SECURITY NUMBER 8. AGE (in yrs. last birthday) 5. SEX 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 92 DAY HOURS MIN. 1 M 2 F VRS 578-30-4231 May 11,1902 Illinois 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery 10a STATE 10b COUNTY 10c CITY TOWN OR LOCATION Maryland Montgomery 1 YES 2 NO Silver Spring FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20906 2808 Cairncross Terrace U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-il yes, specify Cuban, Maxicen, Puerta Rican, etc.) 1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES BY 3 X Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION

Work done during most of working ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 8 Chief Telephone Operator Catholic University опсе. 17, FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) Ħ Anthony McNerny BE McCann notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary LaVelle Wheatley 2808 Cairncross Terrace Silver Spring, MD 20906 9 20s. METNOD OF DISPOSITION
1 □ Burlai 2 □ Cremetion 3 □ Removal from State
4 □ Donetion 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State TINE Metropolitan Crematory 12/4/94 Alexandria, Virginia 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 23. PART I. Enter the diseases, or complications that caused tha death. Do not enter tha mode of dying, euch as cardiec or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death me disesse or condition Hentra TEON MUNIGUELLE DUE TO (OR AS A CONSEQUENCE OF): recuiting in deeth) nourecence CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate Cerelia vercular
DUE TO (OR AS A CONSEQUENCE OF): ceuse. Enter UNDERLYING CAUSE (Diseese or Injury that initiated events resulting in deeth) LAST 6 PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 YES 2 NO OF DEATHS 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 26e, DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY - At home, lerm, street, lectory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town States 28 Is 3 Suicide 6 Could not be COMPLETED 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If item 2 29e. CERTIFIER
(Check not)
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner se stated. 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H Ellen MD 12/2/94 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 6525 Belevest Rd Hyattsville MD 20782 NORTON ELSON

32. REGISTRAR'S SIGNATURE

Julia Davidson-Randall



BALTIMORE MARYI AND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687601

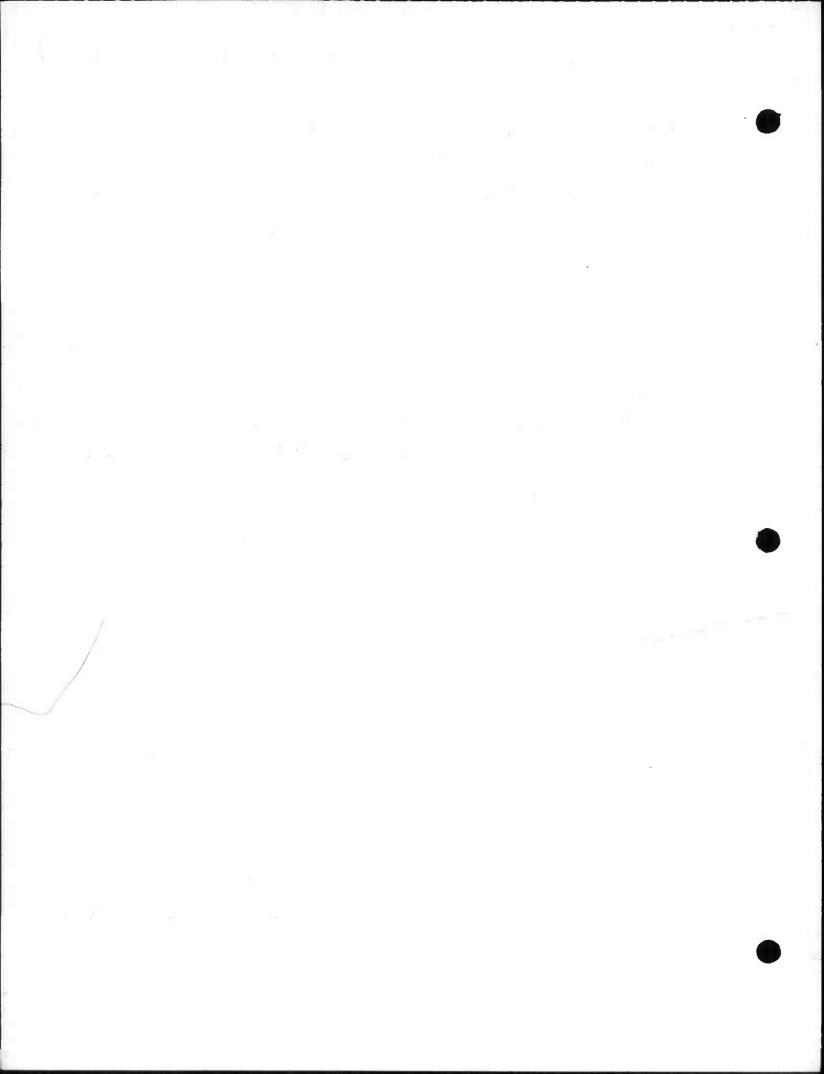
Amended # 19a 12/1/94 MRT Montgom STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 1:30 ROSE CONNOR NOV 94 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birtnday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 1 M 2 XF DAYS HOURS YRS 013-30-2960 57 June 12, 1937 Massachusetts 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 20255 RED BUCKEYE COURT GERMANTOWN MONTGOMERY 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Rhode Island 1 M YES 2 NO Washington North Kingstown FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 136 Fishing Cove Road 02852 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \(\subseteq \text{YES} \) 2 \(\subseteq \text{NO} \) IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yee, specify Cuben, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TES 2 NO Specify: Specify: BY 3 🗌 Widowed 4 📗 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest gi Elementary/Secondary (0-12) College (1-4 or 5 +) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surnem BE <u>Peter</u> <u>DeLuca</u> Jeannette (Unknown) 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 John C. Connor, 136 Fishing Cove Road North Kingstown, RI 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) Nov. 29, 1994 20e. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 1 Burlel 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) Rhode East Bay Crematory Providence, Island 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda- Chevy Chase, Inc. 7557 Avenue Bethesda, Maryland 20814 Xelnan Wisconsin 3501 Lestos M00202 23. PART I. Enter tha disasses, or complications that caused tha deeth. Do not anter the mode of dying, such as cerdisc or respiretory strest, ahock, or heart fellura. List only one cause on each line. Interval Between **Onsat and Desth** IMMEDIATE CAUSE (Final disesse or condition ATHOROS CUSTION C CASOLOVAS CULAND 150BSG reculting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially liet conditions, OUE TO (OR AS A CONSEQUENCE OF): If eny, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL 1 PYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 4 | Nursing Home 5 | Residence (Schother (Specify) AT SCENE XXVES 2 □ NO Inpatient 2 - ER/Outpatient 3 - DOA 28e. DATE OF INJURY (Month, Day, Yeer) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City of Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER

Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner as stated. 2 DEPENDENT ON the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner ee steted. 29b. AIGNATURE AND TITLE OF QUITTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 10re NOV 26,1994 O.C.M.E. 2 NAME AND ADORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALYDAND B. KORFILMO

32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201



DIVISION OF VITAL RECORDS, P.O. BOX 68760

fler death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit poval.	al examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perrole filled within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

nit. Pages 1, 2, 3 should

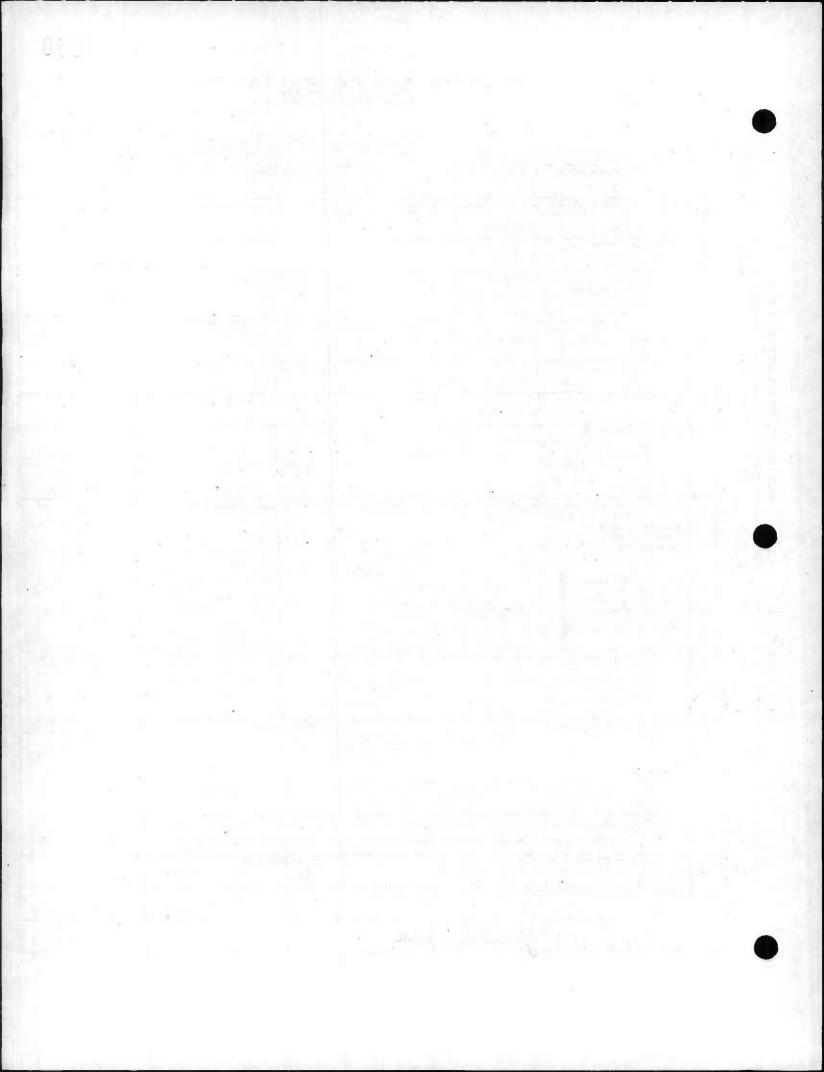
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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /				DEAT		MENTA	L HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE	OF DEATH	Mark	3. TIME OF DEATH									
	Louise Duv						Nove		27, 1	994	4:15 P. M				
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	est birthday) F UNDER 1 YEAR MONTHS DAYS			IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year)			8. BIRTI	HPLACE (State or Foreign		
	216-46-5411	1 🗆 M 2 💢X	121		YRS.					6, 1	_				
DIRECTOR	99. FACILITY NAME (If not institution, give s 1912 Cuire Dri RESIDENCE OF DECEDENT	ME		verr	OR LOCATI	ON OF D	EATH		undel						
EC	10e. STATE 10b. COUNT	10c. CIT	Y, TOWN	OR LOCA	TION				10d. INSIDE CITY						
	Maryland Anne	5	Seve	m					LIMITS?						
MA	10e. STREET AND NUMBER		101. ZIP CODE							WNAT COUNTRY?					
Ä	1912 Cuire Driv		21144							ted	States				
COMPLETED BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Wildowed 4 Divorced	MED	13. WAS DECENDENT OF HISPANI If yes, specify Cuban, Mexican 1 YES 2 XXO Specify:						Blac	E — American Indian, k, White, etc. #y: White					
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 years 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE										RE-LIE				
BE CO	17. FATHER'S NAME (First, Middle, Lest) William Alvan Duvall, Sr. 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Melissa Virgie Hughes														
TO	19e. INFORMANT'S NAME (Type/Print) Theodore Parker Cowgill 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) same as #10														
	20e. METHOD OF DISPOSITION XXBurlel 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece) Cedar Hill Cemetery November 30, 1994 Suitland, Maryland														
	21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705														
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory srrest, abook, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) CAUSE (Disease or injury)														
NOIL	Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):														
TIFICATION	that initiated events														
CER	resulting in death) LAST														
PHYSICIAN: MEDICAL	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO											AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
AN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)														
SIC	EXAMINER?	HOSPITAL:	ER/Outpatient 3	[] DOA	OTHE	R:		/							
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	26a. DATE OI	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK?							Presidence 8 □ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 2 ☑ NO					
8	2 Accident investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, building, stc. (Specify)						•		281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)				Route Number,		
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE												and menner as stated		
	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated. 29c. LICENSE NUMBER 29c. DATE SIGNED (Month Day Mark)														
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 298. DATE SIGNED (Month, Day, Year)										0 1				

29a, CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my le 2 MEDICAL EXAMINER: On the basis of 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

11-2894 36 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) conta

32. REGISTRAR'S SIGNATURE
Julia Davidson-Randale

31. DATE FILED (Month, Day, Year)
NOV 2 9 1994



Amended #1 11/29/94 MRT Montgomery Country

	1 - STATE REGISTRAR	SIAIE UP N		DEPAR					MENTAL HÝGIĚN REG. NO.		of f		
	1. DECEDENT'S NAME (First, Middle, Last)	CAROLYN	CLARK	J	0	Clo	arK		2. DATE OF DEATH DATE NOVEMBER		3. TIME OF DEATH 1994 12:30 PM		
1	4. SOCIAL SECURITY NUMBER	5. SEX	st birthday)	MONTHS DAYS HE			24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
Ì	467-18-7583 9e. FACILITY NAME (If not institution, give	1 M 2 F	87	YRS.					July 22,19		Texas		
						ever		ON OF DE	ATN				
	RESIDENCE OF DECEDENT	Prince George's Hospital RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CT Maryland Prince George's (100. STREET AND NUMBER (100. STREET AND NUM								Prince George's			
	700								10d, INSIDE CITY LIMITS?				
										40 0171	1 ☐ YES 2 ☑ NO ZEN OF WHAT COUNTRY?		
	6201 Kilmer Stree			100	207			U.S.A.					
	11. MARITAL STATUS	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify)											
	1 Never Merried 2 Married 3 X Widowed 4 Divorced				n, Mexicen Specify	, Puerto Ricen, etc.)		Specify: White					
	15. DECEDENT'S EDU (Specify only highest grade		(G	CEDENT'S	work done	during mos		10	16b. KIND OF BUS	SINESS/IND	USTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5 +	'	. Do NOT u									
	17. FATNER'S NAME (First, Middle, Last)	4	Tea	cher			18 MOTI	HED'C NAM	Educa E (First, Middle, Meiden				
	James William Gr	iffin							a Daisy Mc	,			
	19e. INFORMANT'S NAME (Type/Print)	111111	19	b. MAILING	ADDRES	S (Street a			oute Number, City or Town		Code)		
	Claudia Clark Bas	kin	62	201 K	ilme	r St	reet	Che	everly, Ma	rylai	nd 20785		
ŀ	20e. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremetion 3 🐰 Ren	noval from State	20b. PLACE of cemetery, cre				nie of		-7		City or Town, State		
ŀ	4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE ## FUNERAL SERVICE ##	emetery 12/01/94 Troy, Texas 22. NAME AND ADDRESS OF FACILITY											
	* Steven Da	troud			Fr	anci	s J.	Col.	lins Funer				
	23. PART i. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, euch as cerdiec or reepiretory arrest, ehock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):									eet, Approximete Interval Between Onset and Death			
ı	PART II. Other eignificant condition	ns contributing to	deeth but not r	reculting	in the ur	nderlying	ceuse g	jiven in F	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
									1 YES 2		COMPLETION OF CAUSE OF DEATH?		
										-1	1 🗆 YES 2 🗀 NO		
	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAL		TH YE			UNC	ERTAIN					
i	EXAMINER?	HOSPITAL:			OTHE	R:	5 Da	eldanaa (Other (Specify)				
	27. MANNER OF DEATH	28e. DATE OF I	NJURY	28b. TIM		28c. INJU	JRY AT	Y	28d. DESCRIBE NOW IN	JURY OCC	CURED		
ì	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 [NO .					
	3 Suicide 6 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									or Rural Route Number,			
									o the cause(e) end men		ed. e cause(e) end menner ee stated.		
	29b. SIGNATURE AND JITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WITH	ner	~~?	ux	9		29c. LICE	O (2	808	29d. DATE	SIGNED (Month, Day, Your) 11-26, 1994		
	DON B.CA	MERO	N, M) "	HE	UE	A.	70	MD Z	2	85		
	31. DATE FILED (Month, Day, Year) N () / 9 () 100	32. REGISTRAF	avidson-A	Prode M	2_								
JL	11016 3 133	7 June	-WINDOW-N										

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. The forms after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / I			MENTAL HYGIENE
CE	RTIFICATE C	OF DEATH	REG. NO.

	1. DECEDENT'S NAME (First,	Miridia I anti													
	CLAUSE	A	. CAST	+						2. DATE OF	DEATH DA) (24ª	3. TIME OF DEATH 1545 M	
			5. SEX	5. SEX 6. AGE (In yrs.						7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHP		IPLACE (State or Foreign	
	230-14-3859 12(M 2 □ F). 9e. FACILITY NAME (If not institution, give street and number)			70	YRS. MONTHS			2/13/3					CAROLINA		
œ			96, CIT	Y, TOWN	OR LOCAT	ION OF DE	ATH		^-	NTY OF D	EATH				
DIRECTOR	WASHINGTON RESIDENCE OF DEC	EDENT	MUSI THE	DU	4	LIGK	DM) HOU	KIN	40		mo	ULO C	mery	
3,50	10a. STATE	10c. Cl	10c, CITY, TOWH OR LOCATION 10d, INSIDE								10d, INSIDE CITY LIMITS?				
	MD. PRINCE GEORGES						HYAT	TSVI	LLE					1X YES 2 NO	
FUNERAL	10s. STREET AND NUMBER	10f. ZIP CODE							10g. CITIZEN OF WHAT COUNTRY?						
Ę	5305 CHESAPEAKE RD.					20781					0781 U				
5	11. MARITAL STATUS 1 Never Married 2 Merried 12. WAS OECEDENT EVER IN U.S. FORCES? 1 YES 2					2 NO If yea, specify Cuban, Mex					HISPANIC ORIGIN? (Specify Yea or No. 14. RACE - Black,)				
B⊀	3 Widowed 4 Divo		IF YES, GIVE W		В							Speci	WHITE		
9	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)	18	e. DECEDENT'S	work done	durina me	ON ost of worki	na	16b. KIN	ID OF BUS	SINESS/INI			
COMPLET	Elementary/Secondary (0		College (1-4 or 5+)	life. Do NOT u	se retired.)									
N N	17. FATHER'S NAME (First, M	Velette 1 o ath			WAREH	OUSE.	MAN						Y		
		ORGE	ALFRED		CII			18. MOT		AE (First, Middl	le, Maiden				
BE	19a, INFORMANT'S NAME (7		ALTREL) CA	SH Lade Mall IN	2 ADDRES	e /Ctmat	and Marsha		ESSIE	Sibra on Form		NCER		
2	person the property of	J. CAS	SH		244									E. FLA. 32246	
!	20a. METHOD OF OISPOSIT	ION		20b. PL	ACE AND DATE	/ "			17 TOP	DATE			Cify or To		
	1 Donation 5 Other		oval from State	cemeter CH	AMBERS	CRE	MATC	RY	-	12/2		RIVE	RDAL	E. MD.	
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	_		22.	NAME A	ND ADDRE	SS OF FAC	HLITY					
	1911A	· Chi	anleus	all	M0009	1	W. W	. CH	AMBEI	RS CO.	, RI	VERD.	ALE.	MD. 20737	
	23. PART i. Enter the di	seeses, or c	complications thet	caused th	e death. Do	not ente	r the mo	de of dy	ing, such	as cardiec	or respi	ratory er	rest,	Approximate	
	shock, or heert fallure. List only ona cause on aech line. IMMEDIATE CAUSE (Final Onset end Daath														
	disease or condition resulting in deeth)	→	respi	vatory	tai	lure	2								
	Due TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):														
NO.															
Ā	if any, leading to imme- cause. Enter UNDERLY	NG	D: 44	use F	Alvent	er	Down	ACP							
Ĕ	CAUSE (Disease or injuthat initiated events		DUE TO	OR AS A CO		_	2	7	0			9			
CERTIFICATION	resulting in deeth) LAS	T L	. Card	1000	runone	ry	134	2255	for	CA	BG	_			
- 11	PART II. Other significa	nt condition	s contributing to	deeth but i	not resulting	in the u	nderlyin	g cause	given in l	Part I. 24	, WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS	
MEDICAL										1	PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE	
										_ ''	YES 2	NO.		OF DEATH? 1 YES 2 NO	
	DID TOBACCO	USE C	ONTRIBUTE	TO CA	USE OF	DEAT	rh y	ES 🕫	NO					1	
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?									ck only one)					
)S	1 TES 2 NO		HOSPITAL:	ER/Outpatle	nt 3 🗆 DOA	OTHE		10 5 🗆 R	ealdenca	6 Other (Sp	ecify)				
H H	27. MANNER OF DEATH 1 Notural 5	Daniel -	28a. DATE OF (Month, Da	INJURY ry, Year)	28b, Til	JURY		URY AT ORK?		28d. DESCRI	BE HOW II	NJURY OC	CURED		
B	2 Accident	Pending Investigation				М		YES 2 [NO						
									r or Rural F	loute Number,					
۳	29a. CERTIFIER	IFYING PHYSI	CIAN: To the best of	my knowlede	e death occur	red at the	time dete	and place	and due	to the operate	and man		4-4		
COMPLETED	000)													i) and manner sa stated.	
								BER / O		29d. DAT	TE SIGNED	(Month Day, Year)			
TO BE	· hollon	Uson	MI					1	120	362		> /	1/30	794	
	30. NAME AND ADDRESS OF NORTON	EL.	5 ON	65	27) (Typ)	Be	lo	rest	L Z	2 F	lgai	tsvi	lle	MI)	
	DEC 0 2 19	94 <i>A</i>	32. BEGISTRAI	n's signatu	RE						V				
الـــــــــــــــــــــــــــــــــــــ		- (1		-	along the										

AND THE RESERVE OF THE PARTY OF

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
DONNA		MARIE	CURE						NOV.	30,	19	94 ^{EAR}	12:40 Pm
4. SOCIAL SECURITY NUMB		5. SEX		s. last birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH		6. BIRTI	IPLACE (State or Foreign
264-02-8137		1 □ M 2 🂢 F	4	1 YRS.	MONTHS	DAYS	HOURS	MIN.	Dec.	15,	1952	Counti	rida
90. FACILITY NAME (If not in:	stitution, give si	reet end number)		9b. CIT	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA								
7344 Landove						1	ando	ver			Pri	nce	George's
RESIDENCE OF DEC		u					ando	VCI				IICC	deorge 3
10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
Maryland	Pri	nce Geor	ge's			L	.ando	ver					1 TES 2 NO
10e. STREET AND NUMBER						10	. ZIP COD				10g. CIT	IZEN OF V	VHAT COUNTRY?
7344 Landove	er Roa	d #E					2	0785			Un	ited	States
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1			13.	WAS DEC	ENDENT (F HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RACI	E American Indian, c, White, etc.
1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W					2 NO		n, Puerto Rica /:	n, etc.)			Black
													Втаск
(Specify only	EDENT'S EDUC highest grade		160	(Give kind of life. Do NOT u	work done	during mo	DN ost of workin	ng	16b, KIN	ID OF BUS	INESS/IN	DUSTRY	
Elementery/Secondary (0	-12)	College (1-4 or 5								Moto	wo l =		
l				nginee	-								
17. FATHER'S NAME (First, Mi	John		Cure						ME (First, Midd		-		Taulou
40 - 105000000000000000000000000000000000			cure					Blan			Α		Taylor
Nicole Cure		(Daughter	ا ۱	Same			and Number	or Rural I	Poute Number, (City or Town	, State, Zij	p Code)	
20e. METHOD OF DISPOSITI		(Daugnite											
1 K Burlel 2 - Cremetio	n 3 🗆 Reme	oval from State	cemetery	CE AND DATE	ther place)			DATE			City or To	
4 Donation 5 Other 21. SIGNATURE OF FUNERAL		ENGEE		enwood			_		112-3	Was	shing	qton,	D.C.
E)	(LINGEL			Ŕ	app	Fune	ra l	Servic	es.	P.A.		
· Cle	en	A. A	OR	P					Silv			a. M	D 20910
23. PART I. Enter the di	seesea, or c	omplications the	t caused the	deeth. Do	not enter	r the mo	de of dy	ing, aucl	h ea cerdlec	or reepli	etory ar	reat,	Approximete
iMMEDIATE CAUSE (Fin		List only one ceu	se on each	line.									interval Between Onset and Death
diseese or condition	→	_	Respi	ratory	Ins	uffi	cien	CV					week
resulting in death)		DUE TO		NSEQUENCE O				-5					- HOCK
			Acqui	red Im	mune	Def	icie	ncv	Syndro	me			months
Sequentially liet conditi if any, leading to immed		DUE TO	(OR AS A CON	SEQUENCE O	F):			J	J				
Cause. Enter UNDERLY		.											
that initiated eventa resulting in deeth) LAST	·	DUE TO	(OR AS A COR	SEQUENCE O	F):								
resulting in deetil) LAS		1											
PART II. Other aignifice	nt condition	e contributing to	deeth but n	ot resulting	in the u	nderivin	a ceuse o	iven in	Pert i. 24	. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS
							0.00			PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									- 11	YES 2	Ю №		OF DEATH?
DID TORACCO III	SE CONT	DIRLITE TO CA	HICE OF D	EATL W	-c 🗀	NO E	1 11514	EDTAIN					1 TYES 2 NO
DID TOBACCO US		IDUIE IU CA		LACE OF DEA		_	1 UNC	EKIAII	<u>ч </u>				
EXAMINER?	- Inchione	HOSPITAL:			OTHE	R:			12.12				
1 YES 2 NO		1 Inpatient 2 I		26b, TIM		28c. INJ		eldence	6 Other (Sp			OUBES	
1 Netural 5 🗆 f	Pending	(Month, D			JURY	WC	PRK?	I NO	26d. DEŞCRI	DE NOW IN	DUHY OC	COHED	
a C action	nvestigation	26e. PLACE O	F IN HIDV _ A	t home form	-1			J NO	201 1 201712	A1 (D)			
	Could not be letermined	building,	atc. (Specify)	t nome, term,	streat, rec	tory, offic	•		281. LOCATIO City or To	wn, State)	nd Numbe	r or Hurel F	loute Number,
29e. CERTIFIER											-		
(Check only		CIAN: To the best of											
2 MEDIC		T: On the beele of e	amination end	i/or Investigatio	on, In my o	opinion, d	eath occur	ed at the	time, date end	piece, end	due to ti	he ceuse(e) end manner ee stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER	0000	. 1					NSE NUM			29d. DAT	E SIGNED	(Month, Day, Year)
martin	NUU	XXX	4				D 2	3473	3		► N	ov.	30, 1994
30. NAME AND ADDRESS OF													
Martin D. V			25 Gree	enway	Cent	er D	r. #	205,	Gree	nbel	t, M	D 20	770-3532
DEC 0 2	4	A	ASSIGNATUR								_		

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be neitfiled at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													
	ANGEL	INE	RITA	CAL	CILLA	A				NOV			1994	6:45 AM
	4. SOCIAL SECURITY NUME	BER	5. SEX 6. AGE (in yrs. last		last birthday)		R 1 YEAR	-	R 24 HRS.	7. DATE	OF BIRTH		/-	LACE (State or Foreign
	072-07-51	+2	1 M 2 F	83	83 YRS. MONTHS DAYS			HOURS MIN. (Month, Day, Year) SEPT. 20				1911	YORK	
	9a. FACILITY NAME (If not in	9a. FACILITY NAME (If not institution, give street and number)					Y, TOWN	OR LOCAT	ION OF DE			9c. COUNTY OF DEATH		
DIRECTOR	WASHINGTON ADVENTIST HOS						TAI	AKOMA PARK				MONTGOMERY		
E	10a. STATE	10b. COUNTY			10c. CI	ry, TOWN	OR LOCA	TION						10d. INSIDE CITY
E	MD.	PRI	NCE GEORG	GES			BLAD	ENSB	URG					LIMITS?
A	10e. STREET AND NUMBER							. ZIP COD		-		10g. CIT	IZEN OF WI	HAT COUNTRY?
ER	5999 EI	MERSON	ST. #10	3				2	0710	U.S.				. A.
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13	. WAS DE	ENDENT	OF HISPAN	VIC ORIGIN	? (Specify Yes	or No-	14. RACE	- American Indian, White, atc.
ВУ	1 Never Merried 2 3 Widowed 4 Divo		IF YES, GIVE Y	YES 2	- INO				Specify	n, Puerlo R y:	HCBN, MC.)		Specify	:
		EDENT'S EDUC	ATION	T 40.	2505251111					1		1		WHITE
COMPLETED	(Specify onl	y highest grade	completed)		(Give kind of life. Do NOT u	work done	during me	ost of work	ing	166.	KIND OF BUS	SINESS/INI	DUSTRY	
PLE	Elementery/Secondary (0	1-12)	College (1-4 or 5		AITRE			TEND:	ER			ਸੁਸ਼ਾਵਾ	raura:	Viii)
OM	17. FATHER'S NAME (First, M	iddle, Last)	=							ME /First. N	tiddle, Maiden		LAONA	IAT
	DIEGO		CANCII	LLA						SEPHI			IRGA	
) BE	19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRES	SS (Street	nd Numbe			er, City or Tow			
2	JOANNE	HARV	700D		114	05	FIEL	DSTO	NE L	A F	RESTON	. VA.	220	91
	20a. METHOD OF DISPOSIT		oval from State	20b. PLAC	E AND DATE	OF DISPO	SITION /N			DATE			City or Tow	
	4 Donetion 3 Other	(Specify)		_ CH	AMBER	S CR	EMAT	ORY		11/28	R	IVERI	DALE,	MD.
- 1	21. SIGNATURE OF FUNERA	L SERVICE LIC	EMSEX /	1		22	. NAME A	ND ADDRE	ESS OF FA	CILITY				
	WW.	Cha	mbers	all M	00091	W	. W.	CHA	MBER	S CO.	. RIV	ERDAI	LE. M	D.20737
	23. PART I. Enter the d	Iseases, or c	omplications the	t caused the	death. Do	not enta	r tha mo	de of dy	ing, suc	h aa card	lac or respi	ratory ar	rest,	Approximate
	iMMEDIATE CAUSE (Fin		list only one cat	Jsa on each I	ina.									Interval Between Onset and Death
	disease or condition carbin a. CARDIO-PULMONARY FAILURE													
	DUE TO (OR AS A CONSEQUENCE OF):													
Z	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): TRACHY ARYTHMIAS													
Ĕ I														
은	CAUSE (Disease or Inju			(OR AS A CON										
CERTIFICATION	reauiting in death) LAS	т		EUMONIA										İ
뜅	DAST # 011 - 1				ot resulting in the underlying cause given in Part I. 24a, WAS								1	
MEDICAL					t rasulting	in tha u	ndariyin	g cause	givan in	Part I.	24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS WAILABLE PRIOR TO
ă	CARC.	LNOMA	OF LARYN	Χ						_	1 YES 2	₩ NO		COMPLETION OF CAUSE OF DEATH?
	DID =0.04 660 11	ar an I											'	T YES 2 NO
PHYSICIAN:	DID TOBACCO U	- 7	RIBUTE TO CA					UNC	CERTAIN	1 X				
<u> </u>	EXAMINER?	O MEDICAL	HOSPITAL:		ACE OF DEA	OTHE	R:			D. 069				
₹	27. MANNER OF DEATH		1 Nopetlant 2		3 LI DOA			URY AT	aaldence	6 Other	(Specify) CRIBE HOW II	HILIDY OC	CUBED	
	1 XNatural 5	Pending	(Month, D	lay, Year)		JURY M	WC	PRK?	¬ NO	200. DEG	CHIBE HOW II	NJOHT OC	CONED	
à l	3 Sulates	Investigation	28e. PLACE O	F INJURY — At	home, farm,	street, lec	<u> </u>			28f. LOCA	TION (Street a	nd Numbe	r or Runal Ro	ute Number
		Could not be determined	building,	etc. (Specify)							or Town, State)			,
COMPLETED	29a. CERTIFIER	IFYING PHYSIC	ZAN: To the beat of	my knowledge	death accum	ad at the	elma data	and alone					701	
ĕ														and manner ee stated.
	290. MONA SIRE AND TITLE		-		_	_								
H H	Heralty	Mer	401						1627				NOV a	Month, Day, Year)
임	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEATH (I	TEM 27) (Type	, Print)		ע	1061	١			IVOV a	26, 1994
	DR. REVA						VER	RD	LAN	DOVE	R, MD.			
	31. DATE FILED (Month, Day,		32. REGISTRA	D'S SIGNATURE							-			
	NUV 2	9 199	4 gruha	Davidson	-Mande	الألم								
														DHMH-16 Rev 1/89

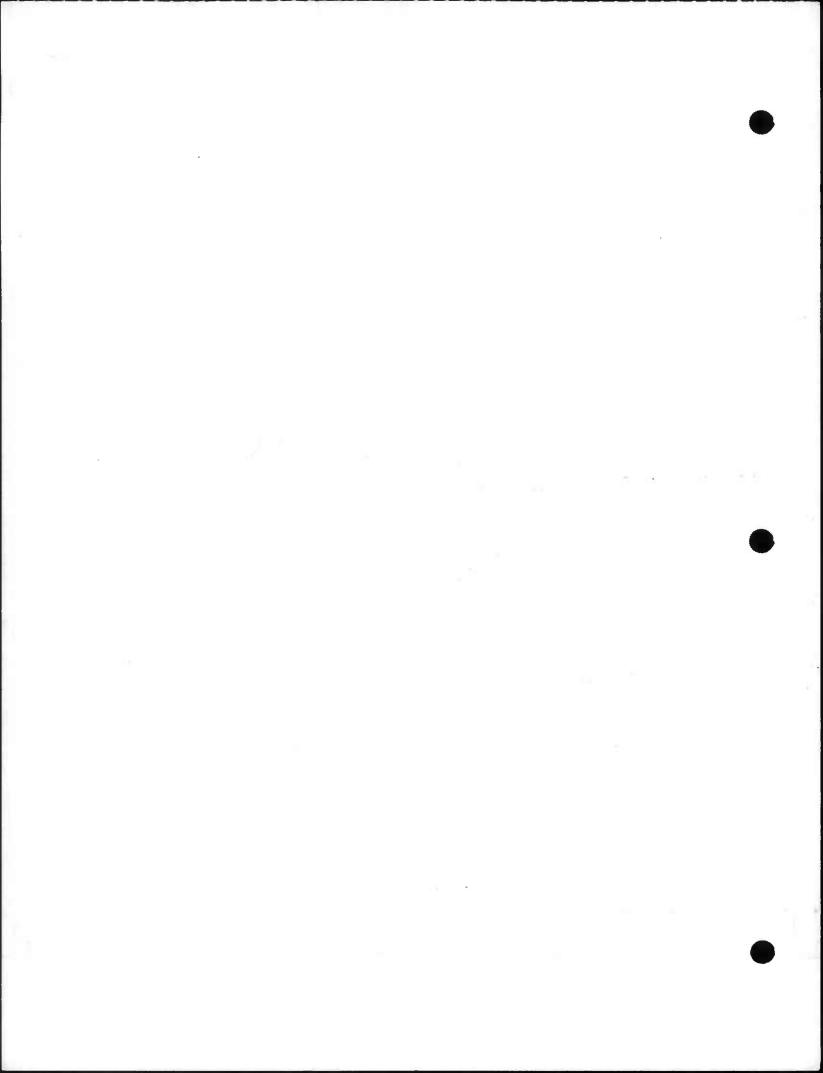


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s after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should emoval.	dical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	

	1 - FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPARTI	MENT OF H	EALTH AN	D MEN	TAL HYGIEN	E			
11	1. DECEDENT'S NAME (First, Middle, Last)						TE OF DEATH		13	3. TIME OF DEA	ATH
- 9	Marj	orie Elizal	beth	Co1	e	NOV	rember 2	4. 19	VEAR	9:00	Ам
- 3	4. SOCIAL SECURITY NUMBER 5. S		s. last birthday)	F UNDER t YEAR	IF UNDER 24 HR	s. 7. DA	TE OF BIRTH	Y		LACE (State or I	
	194-12-2196	□ M 2 💢 F 68	YRS.	ONTHS DAYS	HOURS MIN	i. (M	onth, Day, Year)	- 1	Country)		
	9e. FACILITY NAME (If not Institution, give street e			b. CITY, TOWN O	R LOCATION OF		g. 5, 19	9c, COUNT		sylvan:	ıa_
œ	13615 Grenoble Dri			Rocky		DEATH			tgom		
읝	RESIDENCE OF DECEDENT	V C		NOCKV	TTTE			PIOI.	regon	тету	
DIRECTOR	10e. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCAT	ION				1	IOd. INSIDE CIT	γ
	Maryland Montgom	nery	F	Rockvil	le				1	YES 2	NO
AL	10e. STREET AND NUMBER				ZIP CODE			10g. CITIZI	EN OF WH	AT COUNTRY?	
FUNERAL	13615 Grenoble Dri	ive			20853			l IIn	ited	States	
5		WAS DECEDENT EVER IN U.S	. ARMED		ENDENT OF HIS		GIN? (Specify Yes		4. RACE -	- American Ind	
BY		FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES			cify Cuben, Me 2 📉 NO Sp		to Rican, atc.)		Specify:	White, etc.	
										White	
COMPLETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	N 164 pleted)	Give kind of work	done during mos	N it of working		16b. KIND OF BUS	INESS/INDU	STRY		
ا ت		llega (1-4 or 5+)	me. Do NOI use n	etired.)							
Σ	12		Home	maker			Own I				
8	17. FATHER'S NAME (First, Middle, Last)						st, Middle, Maiden				
BE	Charles McDermott	· · · · · · · · · · · · · · · · · · ·					McLaugh				
٩	19e. INFORMANT'S NAME (Type/Print)						umber, City or Town				
	Frank J. Cole, Jr.		13615 G	renoble	Drive	, Ro	ckville,				3
	20a. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Removal f	from State 20b. PLA	CE AND DATE OF I	DISPOSITION (Nei place)	me of 2/1/	94		CATION — CI			
	4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE	Arli	ington N	ational	L Cemet	ery	Ar1	ingtor	n, Vi	irginia	1
	50 1 0 mm	1/1 //100	0831	Robert	A PU	mphr	ey Funer	cal Ho	ome/		i i
	Darbara Jo/1/C/	y july you	mence	Avenue	Rock	nc. ville	ey Funer 300 Wes	land 2	1tgon 20850	nery)-2805	
	23. PART I. Enter the diseases, pr/comp	licetions that caused the	deeth. Do not	enter the mod	de of dying, s	such as c	ardiac or respin	ratory arres	вŧ,	Approxin	
	shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final										
	disease or condition resulting in death)										ths
	DUE TO (OR AS A COMBEQUENCE OF										
Z	Sacrantelly list and distance by Peripheral Vascular Disease										
Ĕ	Sequentielly list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	Diabetes Mel						year		years	;
# 1	that initiated events resulting in death) LAST	DUE TO (OR AS A COM	NSEOUENCE OF):								
CERTIFICATION	d									-	
AL C	PART II. Other significent conditions con	ntributing to deeth but n	Dt resulting in (the underlying	ceuse given	In Part I.	24s. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY I	INDINGS
<u>১</u>	Cerebral Vascular			, ,			PERFOR	MED?		WAILABLE PRIOF	
	Coronary Artery Di	50350					1 TYES 2	⊠ NO	0	F DEATH?	
Σ	DID TOBACCO USE CONTRIBU		EATH VEC		LINICEDT	AINI 🗆			1 1	☐ YES 2 💥	NO
₹ I	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		DIACEKIA	AIIV L					
PHYSICIAN: MEDIC		SPITAL: Inpatient 2 - ER/Outpatien	0	THER:	. 2		40 41				
ΞÏ	27. MANNER OF DEATH	28e, DATE OF INJURY	28b. TIME O	F 28c, INJU		-	DESCRIBE HOW IN	JURY OCCU	RED		
	1 Natural 5 Pending	(Month, Day, Year)	INJUR		RK? ES 2 NO						- 1
BY	2 Sulatio	28a. PLACE OF INJURY - A	it home, ferm, atre-			281. L	OCATION (Street a	nd Number o	Rumi Rou	ite Number	
逆	4 Homicide B Could not be	building, etc. (Specify)				C	ity or Town, State)				
COMPLETED	290. CERTIFIER 1 X CERTIFYING PHYSICIAN:	To the head of our boards do	death are seened		-1-40 SOL	10000					
₽	Check only	To the best of my knowledge the basis of examination end								0	
8			POT INVESTIGATION, 1	ir my opinion, u	ann occured at	tne time, o	ate end place, and	due to the	ceuse(s) a	nd menner as	stated.
88	296. SIGNATURE AND TITLE OF CENTIFIER		/_	222	29c. LICENSE I					fonth, Day, Year)	
စ္	TO SAME AND ADDRESS		-/	///	D005	57		Nov	embe	r 25,	1994
	30 NAME AND ADDRESS OF PERSON WHO COM			,				0007			
	Raymond T. Benack, I			Lve, Wh	eaton,	Mary	Tand 2	0906-	4465		
		32. REGISTRAR'S SIGNATUR									
	NOV 2 8 1994	Julia Buildon	Mandell								
										DHMH-1	6 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

INSTRUCTION OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with source after death. Page 6 may be retained by the hospital or attending physician.	THINERAL DIFFERDR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	TANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ifter death. Page 6 may be retained by the hospital or attending physician.	r the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in an	cal examiner must be notified at once.

	FOR STATE OF MADVI AND / DEDAD	THENT OF USALTH AND	MENTAL HVOIENE									
	4 STATE SIMIL OF MANILAND / DEFAN	ICATE OF DEATH	REG. NO.									
1	1. DECEDENT'S NAME (First, Middle, Last)	er.	2. DATE OF DEATH DAY		TIME OF DEATH							
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest a frame) 1 □ M 2 ☑ F 49 49 49	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 26, 1	Country)	ACE (State or Foreign							
~	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF D		9c. COUNTY OF DEA								
10T	Prince George's Hospital	Cheverly		Prince George's								
DIRECTOR	10e. STATE 10b. COUNTY 10c. CIT	y, town or Location per Marlboro			Od. INSIDE CITY LIMITS? X YES 2 NO							
FUNERAL	10. STREET AND NUMBER 10705 Tyrone Drive	101. ZIP COOE 20772		10g. CITIZEN OF WH United St	AT COUNTRY?							
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci	an, Puarto Rican, etc.)									
COMPLETED	(Specify only highest grade completed) (Give kind of life. Do NOT us (Give kind of life. Do NOT us)	USUAL OCCUPATION work done during most of working se retired.)	16b. KIND OF BUSH	NESS/INDUSTRY								
MP	12 House			vate								
	Grover Lucas		ame (First, Middle, Meiden Si ra Kellv	iurname)								
) BE		ADDRESS (Street and Number or Rural	7	State, Zip Code)								
5	James T. Cooper 10705	Tyrone Drive, U	pper Marlbon	ro, Maryl	and 20772							
	20s. METNOD OF DISPOSITION 1\(\text{\text{\$\subset}} \) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \											
	21. NOMETURE OF FUNERAL SERVICE LICENSEE	STEWART FUNERAL	ACILITY HOME									
	28 PART I. Enter the diseases, or complications that caused the deeth. Do r	4001 Benning	Koad, N.E.,	Washingto	n, D.G.							
	ahock, or heart fallure. List only one ceuse on each fine. IMMEDIATE CAUSE (Finel disease or condition	12810	+		Interval Between Onest and Death							
_	resulting in death) a. Due 30 (on as a consequence of	n ass	En d	isens	me							
CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING											
CERTIFICATION	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST	Elleran	1 fa	Mai	gs.							
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting	n the underlying cause given in	Part I. 244 WAS AN A PERFORM	AED?	ENE AUTOPSY FINDINGS MALABLE PRIOR TO OMPLETION OF CAUSE F DEATH?							
ME	DID TONI SCO USE CONTROLLER TO CAUSE OF THE CONTROL			1	☐ YES 2 ☐ NO							
CIAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 126. PLACE OF DEAT HOSPITAL:		N 🗆 📗									
IXSI	1 YES 2 NO 19 inpatient 2 ER/Outpatient 3 DOA	4 🗌 Nursing Home 5 🗆 Residence										
	Natural 5 Pending	E OF 28E INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW IN.	JURY OCCURED								
TED BY	2 Accident 3 Suicide 6 Could not be datarmined 28e PLACE OF INJURY At home, farm, suitiding, etc. (Specify)		261, LOCATION (Street an City or Yawn, State)	of Number or Flurei Ros	de Mundec							
COMPLETED	29s. CERTIFIER [Check only Medical Examiner: On the basis of examination and/or investigation.				nd manner as stated.							
TO/BE CC	50b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NU		29d. DATE SIGNED (A								
2	38 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH ATEM AT (Type,	Print)	21/000	11/2	8/77							

32. ARGISTRARIS SIGNATURE PANDALL

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Washington, D.C.

10d, INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: Black

1XX YES 2 NO

Approximate intarvai Between

WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

COMPLETION OF CAUSE OF DEATH?

1 TYES 2 NO

29d. DATE SIGNED (Month, Day, Year)

#/11

21-91

Onset and Death

9c. COUNTY OF DEATH

PRINCE

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

07.12 M

GEONLO

2. DATE OF DEATH

7. DATE OF BIRTH

NOVEMBER 21.1899

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1. DECEDENT'S NAME (First, Middle, Last,

5. SEX

4. SOCIAL SECURITY NUMBER

P.O. DIVISION OF VITAL RECORDS,

218-24-6268 May 23° 1930 64 YRS. use as the burial-transit permit. Pages 1, 2, 3 should FACILITY NAME (If not instituti 9b. CITY, TOWN OR LOCATION OF DEATH SOUTH & DIRECTOR HOSPITAL toa, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Mary land Prince George's Upper Marlboro toe. STREET AND NUMBER FUNERAL 101. ZIP CODE P.O. Box 323 20772 hospital or attending physician. 11, MARITAL STATUS 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 \(\times \) YES 2 \(\times \) NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-15-0020 If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Wildowed 4 Olvorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe jo lith grade College (1-4 or 5+) Security Guard Self-Employed be detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) retained by the Edward Curtis Bertha E. Holley BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Michelle Curtis (Daughter) 165 Westway Road #103 Greenbelt, Maryland 20770 2 must be 20s, METHOD OF DISPOSITION
1 \(\text{\text{\text{\text{\text{M}}}} \) Burlal 2 \(\text{\tin}\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\tett}\tittt{\text{\texit{\text{\texi}\text{\texit{\text{\texi}\tex{ 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Page 6 may Maryland Veterans' Cemetery 11/28/94 Cheltenham, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner ROllins Funeral Home, Inc. death. 4339 Hunt Place, N.E. Washington, D.C. filled in by the after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, euch as cardiec or reepiratory errest, shock, or heart failure. List only one cause Dn each line. cremation, or IMMEDIATE CAUSE (Final the executed with disease or condition_ completely resulting in death) event, to burial, traumatic CERTIFICATION and Sequentially ilst conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate attending physician 2 prior cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate CAUSE (Disease or injury other Mental Hygiene that initiated events resulting in death) LAST 10 signed by the a Health and Men PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY shows any 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO the State Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: V EXAMINER? OTHER: t TES 2 NO 27. MANNER OF CEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this c 1 Natural 2 Accident DIRECTOR: After the hours after death vitem 28 is mari 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If its 2 MEDICAL EXAMINER: On the besis of investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE M) 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8926 ALMLHASAN U ANSARI Mis 32. REGISTRAN'S PIGNATURE

Julia Day door

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

UNTIS

6. AGE (In yrs. last birthday)

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BALTIMORE, MARYLAND 21215	hours after death. Page 6 may be retained by the hospital or attend
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DIVISION OF VITAL RECORDS. P.O. BO

	REGISTRAR 1. DECEDENT'S HAME (First, Middle, Lest)		<u> </u>		OF DEATH	2. DATE OF OEATH		3. TIME OF DEATH					
	SEATON	N COL	EMAN			NOVEMBER	19 190						
	4. SOCIAL SECURITY HUMBER	5. SEX 6. AG6	E (In yrs. last b		7	7. DATE OF BIRTH	AB	IRTHPLACE (State or Foreign					
	579-20-5526	1 XXM 2 □ F	78	YRS. MONTHS	DAYS HOURS MIN	March 19, 1	1	ishington, D.C.					
H	90. FACILITY HAME (If not institution, give			9b. CITY,	TOWN OR LOCATION OF Chever 1		9c. COUNTY (
5	Prince George's Hos						1 Prince	George's					
DIRECTOR	100100011	ce George's		10c. CITY, TOWN OF Cheve				10d. IHSIDE CITY LIMITS? 1 XES 2 HO					
FUNERAL	100. STREET AND HUMBER 1158 Booker Drive				101. ZIP CODE)743	10g. CITIZEH	OF WHAT COUNTRY?					
	11. MARITAL STATUS 1 Hever Married 2 X Married	12. WAS DECEDENT EYER FORCES? 1 XXYES	IN U.S. ARME			PANIC ORIGIN? (Specify Ye	e or No 14. F	RACE — American Indian, Black, White, etc.					
5	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 ☐ YES 2 📉 NO Specify: Specify:									
	15. DECEDEHT'S EDU (Specify only highest grad	JCATIOH e completed)	(Give	OEHT'S USUAL OCC	CUPATION uring most of working	16b. KIND OF BU	ISIHESS/INDUSTR	ry .					
COMPLEIED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Cle	NOT use retired.)		U.S. Trea	asurer						
5	17. FATHER'S HAME (First, Middle, Last)	0.1			18. MOTHER'S	HAME (First, Middle, Maiden	Surname)						
u l	Seaton H.	Coleman				Lizzie Ander	. 1171						
2	Mrs. Evelyn B. Coleman (Wife) 195. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1158 Booker Drive Capital Heights, Maryland 2074												
	20a METHOD OF DISPOSITIOH 1 XV Burlel 2 Cremetion 3 Ran	noval from Stata	Db. PLACE AHI	DATE OF DISPOSIT	IOH (Name of	OATE 20c. LC	DCATION — City of						
ł	1. Auguste 2 Cremetton 3 Ramoval from Stata Harmoniy Memory Park 11/23/94 Landover, Maryland 1. Buddature of Fuheral Service Licensee Randover												
	4339 Hunt Place, N.E. Washington, D.C. 20019												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
	IMMEDIATE CAUSE (Final Onset and												
	disease or condition resulting in death) a. College of Right Lung												
	GRE TO (OR AS A CONSEQUENCE OF)												
5	Sequentially list conditions, if any, leading to immediate												
CATION	cause. Enter UNDERLYING CAUSE (Disease or injury												
RTIF	CAUSE (Disease or Injury that Initiated events Tresiting in death) LAST												
SER	resulting in death) LAST												
CAL	PART II. Other significent condition	ns contributing to death	but not res	ulting in the und	erlying cause given		AUTOPSY RMED?	24b. WERE AUTOPSY FINDIN					
EDIC						1 _ YES		AVAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?					
ME								1 YES 2 HO					
NY.	DID TOBACCO USE CONT	RIBUTE TO CAUSE (AIN 🗆							
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSBITAL:		OTHER:				-					
2	27. MANNER OF DEATH	npatient 2 ER/Ou			ig Home 5 - Raaldeno	e 6 Other (Specify) 28d. OESCRIBE HOW	IN ILITY OCCUPE						
- 1	S Natural 5 Pending	(Month, Day, Year)		INJURY M	WORK?	280. VESCRIBE NOW	INJUNY OCCURE	,					
	Accident Investigation M 1 YES 2 NO												
à I		building, atc. (Spi	ecffy)			City or Town, State;	,						
LETED BY PHY	3 Suicide 6 Could not be determined	building, atc. (Sp.	ecffy)	accurated at the time									
⋒	3 Suicide 6 Could not be determined 29s. CERTIFIER Check only	building, atc. (So	ecify) wiedge, daath			ue to the cause(s) and ma	nner ee stated,	se(e) and manner ee plate					

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	ID THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the but	Jeath
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		FOR STATE REGISTRAR		STATE OF N		CE	ERTIFIC	CATE	OF			MENT	AL HYGIEN REG. NO.	E		
	1	1. DECEDENT'S NAME (First, MI BULMA RO	liddle, Last) ((Bulmaro	Carı	rera	-Camao	cho)	T D A			2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	4	5. SEX	6. AGE	(In yrs. les			ARRERA IF UNDER 1 YEAR IF UNDER 24 HRS.				E OF BIRTH	1	9.4	3 • 26 PM
		532-90-5432		1 📉 M 2 🗆 F		23		MONTHS	DAYS	HOURS		(Moi	oth, Day, Year)	1971	Count	ny)
		90. FACILITY NAME (If not institu	tution, give s	treet and number)				9b. CITY,	TOWN C	OR LOCA	TION OF D		CII IJ,		NTY OF D	
	DIRECTOR	PRINCE GEOR		HOSPITA	\L			СН	EVE	RLY	<u>. </u>			PRI	NCE	GEORGES
	RE		Ob. COUNTY				10c. CITY,	TOWN O	R LOCAT	TION						10d. INSIDE CITY LIMITS?
		Maryland	Princ	e George	s		River	rda1						· - · · · · · · · · · · · · · · · · · ·		1 X YES 2 NO
	FUNERAL	5425 54th Av	200110							ZIP CO						WHAT COUNTRY?
	JNE	11. MARITAL STATUS	enue	12. WAS DECEDEN	TEVERI	M II C AD	MED.	1 43 1		2073		-110 0010	IN? (Specify Yes		S.A.	
		1 Never Married 2 🗓 Me		FORCES? 1	YES	2 X N		1	f yes, sp		ben, Mexic	an, Puerto	IN? (Specify Yee Rican, etc.)	or No-	Blec	E — Americen Indian, k, White, etc.
	ВУ	3 Widowed 4 Divorce	id			MILL			W	2 111	U Opeci	Me	xican		Spec	Spanish
	TED	15. DECED (Specify only hi	ENT'S EDUC			(G)	CEDENT'S U	ork done o			king	16	b. KIND OF BUS	SINESS/INC	DUSTRY	
	Ě	Elementary/Secondary (0-12	2)	College (1-4 or 5 -	+)		Do NOT use		! ~ la .							
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be notified at once.	ш	17. FATHER'S NAME (First, Middle, Last) Artemio Carrera-Rodriquez 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alberta Camacho-Vera														
tiffed	TO B	190. INFORMANT'S NAME (Type											mber, City or Tow			
e 10	F	Cliscerio Fr	ancis	co Guzma	n	54	408 Ca	arte	rs]	Lane	, Ri	verd	ale, M	ary1a	and 2	20737
ust b		20c. METHOD OF DISPOSITION 1 M Burlai 2 Cremetion 3 Removal from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, cremetory or other place) 4 Donation 5 Other (Specify) MIDICIDAL Carreters The 1 12 / 12 / 12 / 12 / 12 / 12 / 12 / 1														
=		Municipal Carretera Int'l. 12/ /94 Acatlan, Mexico The Homature of Funeral Service Licensee 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A.													Mexico	
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Mai.		lice	16	1-1-6	4			47	39 1	Balt	imor	e Av	e. Hv	attsv	71116	e, MD 20781
cremation, or removal.		23. PANT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate interval Batween Onset and Dasth Approximate interval Batween Onset and Dasth But to (OR AS A CONSEQUENCE OF): Approximate interval Batween Onset and Dasth Due To (OR AS A CONSEQUENCE OF):														
traumatic event, the	z	Sequentially list conditions b.														
aumat	RTIFICATION	Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING														
till a	SI	cause. Enter UNDERLYING CAUSE (Disease or injury														
or other	E	that initiated events resulting in desth) LAST			(On AS A	T CONSEC	DENGE OF ,.									
1	CEI	d														
shows any Injury,	EDICAL	PART II. Other algoliticant	condition	s contributing to	daath b	out not n	esulting in	the un	derlying	g causa	given in	Part I.	24a. WAS AN PERFOR	MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	N: M	DID TOBACCO USE	CONT	PIRITE TO CA	LICE C	ZE DEV	TLI VEC		10 F	1 HKI	CERTAI		1			1 (I) YES 2 NO
n 23	<	25. WAS CASE REFERRED TO M	T	GBOIE TO CA			E OF DEATH	_	_) UN	CERIAI	и П				
item	SICI	EXAMINER? YES 2 \(\square\) NO		HOSPITAL:	111-0			OTHER	t:	e 5 🗆 I	Reeldence	6 D Oth	ner (Specify)			
d, o	¥	27. MANNER OF DEATH		26e. DATE OF (Month, D	INJURY		28b. TIME	OF	28c. INJ	URY AT			SCRIBE HOW II	NJURY OC	CURED	
Is marked,	Ϋ́	1 Netural 5 Per	nding reatigation	unkno			Lev Kores	M	1 🔲 1	RK? YES 2	NO	Su	Circts.	£6600	land	l cut
Is mar	0 8	3 Suicide 8 Coo	uld not be	28a. PLACE O		r — At hor	me, ferm, str	eet, fecto	ory, office	•		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
m 28 l	E		termined			5	reit						ou block	Kenne	My S	treet
/z nours	7			CIAN: To the best of												verde Maylan
TANT	COM	2 X MEDICA			comination	n end/or I	nvestigation,	In my o	pinion, d	eath occ	ured at the	time, de	te end place, an			e) end manner ee stated.
PORTANT:	BE	29b. SIGNATURE AND TITLE OF	F CERTIFIER	N		^				29c. LI	CENSE NU	MBER		29d. DAT		(Month, Day, Year)
E 8	2	30. NAME AND ADDRESS OF PI	ERSON WHI	COMPLETED CALL	SE OF DE	ATU (ITE	4 27) /France (Beint)		0.	C.M.	.E.		NO	OV 2	5,1994
		77/20001		1. King		1	11 P	enn	St	ree	t, I	Balt	imore	, Ma	aryl	and 21201
7		31. DATE FINITH POPULOS	1994	32. geogra	David	ATURE Y	andell									

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	AND ADDRESS OF THE PARTY OF THE
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: The law requires that the death certificate be executed within the course after death. Page 6 may be retained by the hospital or attending physician.	state has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should that the health and Mental Hariene prior to burial cremation, or removal	INPORTANT. II Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execu	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and he find within 72 hours after clearly with the State Dent of Health and Mental Hydiene prior to but	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumative

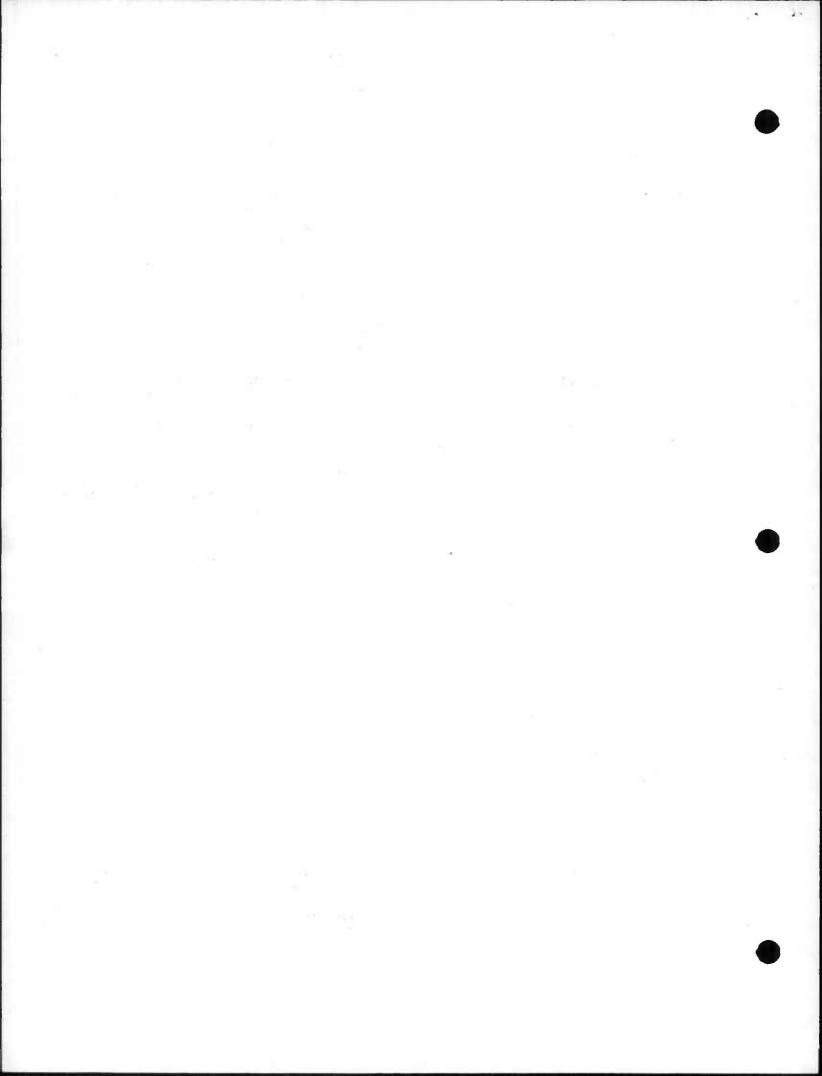
1	1 - STATE O	F MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
1	1. DECEDENT'S NAME (First, Middle, Lest) SALVATORE CIAM	TPA		2. DATE OF DEATH DAY NOV. 21, 1994	year 3. TIME OF DEATN 4 11:30 P M
	4. SOCIAL SECURITY NUMBER 062 24 8493 5. SEX \$\mathbb{X} \square \mathbb{M} \square 2 \square		UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 13, 1923	B. BIRTHPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give street and number, 12229 Heathcliff Court	91	Ellicott City	ATN 9c. CO	Howard
DIRECTOR	Maryland Howard		own or location llicott City		10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 12229 Heathcliff Court		101. ZIP CODE 21042		TIZEN OF WHAT COUNTRY? U.S.A.
BY FUN	1 Name Married 2 V Married FORCES?	DENT EVER IN U.S. ARMED 1 YES 2 NO /E WAR OR DATES	13. WAS DECENDENT OF NISPAN If yes, specify Cuben, Mexica 1 — YES 2 ANO Specify		14. RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 of the control of t		done during most of working	Food	NDUSTRY
BE CON	17. FATHER'S NAME (First, Middle, Lest) Anello Ciampa		Maria	ME (First, Middle, Maiden Surname) DiMario	
5	19a.INFORMANT'S NAME (Type/Print) Marie Pavlides		DRESS (Street and Number or Rural I Heathcliff Cour	t, Ellicott C	ity, Md. 21042
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	20b. PLACE AND DATE OF C	place)	11/26 Marriot	- City or Town, State tsville, Md.
	Harry H. W.	lithe		Œ FUNERAL HOM abia Pike Elli	cott City 21043
	23. PART I. Enter the diseases, or complications shock, or heart allure. Liet only one IMMEDIATE CAUSE (Final disease or condition resulting in death)	and on each line. Brdis flyingting tro (or as a consequence of): Late (or as a consequence of): To (or as a consequence of):			Approximate interval Between Onset and Daati
CERTIFICATION	CAUSE, Enter UNDERLYING	TO (OR AS A CONSEQUENCE OF):	Cerclisma		4 1005
PHYSICIAN: MEDICAL CE	PART II. Other algnificant conditions contributing	to death but not resulting in t	ha undarlying cause given in	Part I. 24a. WAS AN AUTOPS PERFORMED? 1 YES 2 NO	Y 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CO OF DEATH? 1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Ch	eck only one)	
BY PHYS	27. MANNER OF DEATH 28a. OAT	2 ER/Outpetient 3 DOA 4 E OF INJURY th, Day, Year) 28b. TIME O INJURY	Mursing Nome 5 Pesidence F 28c. INJURY AT WORK? 1 YES 2 NO	6 ☐ Other (Specify) 28d. DESCRIBE HOW INJURY O	OCCURED
B	3 Sulcide 26a. PLA	CE OF INJURY — At home, farm, streiling, etc. (Specify)	et, tactory, offica	281. LOCATION (Street and Numb City or Town, State)	per or Rural Route Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the be				
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER A CUT CUT NO.	1 Cons		7821 D	ATE SIGNED (Month, Day Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED WARREN M. R. C.S.S., M.D. ~ 31. DATE FILEO (Month, Day, Year) 32. REGIS	4801 DORSEY HA	HLL DR., ELLICOI	T CITY, Md	21042
	NOV 2 8 1994 Julia	Daviler Randall			

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Market States of		FOR STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL	HYGIEN REG. NO.	_	
		DECEDENT'S NAME (First, Middle, Last) SOCIAL SECURITY NUMBER	LILLIA	7	н. е	EH	2. DATE O	F OEATH DA	9	3. TIME OF OEATH
pino		215-14-8679 9a. FACILITY NAME (If not institution, give str	1 □ M 2 □XF 81	yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF OR	Sept.	Day, Year)		BIRTHPLACE (State or Foreign Country) Maryland
, 2, 3 should	ECTOR	Howard County Gene			Columbi					vard
nit. Pages 1	DIR	10a. STATE 10b. COUNTY	ward		y, town on locat llicott					10d. INSIDE CITY LIMITS? 1 YES 2 X NO
physician. burlal-transit permit. Pages 1,	FUNERAL	4225 Brittany Cir				21043			U.8	OF WHAT COUNTRY?
nding physici s the burial-	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS OECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes, sp	ENDENT OF HISPAN scify Cuban, Maxica 2 X NO Specify	n, Puerto Rk	(Specify Yea can, etc.)	or No 14.	RACE — American Indian, Black, White, stc. Specify: White
spital or attend led for use as	PLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION (completed) (1-4 or 5+)	8a. DECEDENT'S (Give kind of v life. Do NOT us Homema		ON st of working		wn Ho	ome	TRY
by the hospita be detached at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) Christian Schneide:	r			10. MOTHER'S NA Kathar				
5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) Mrs. John R. Hess				nd Number or Rural i				
the 6 may be director, page er must be a		20a. METHOD OF DISPOSITION 1 CSBurial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)			OF DISPOSITION (Na	me of	DATE	20c. LO	CATION — City	dd. 21043 or Town, State Sville, Md.
o funeral di e funeral di al. examiner		21. SIGNATURE OF FUNERAL SERVICE LICE		,	22. NAME AN HARRY	H. WITZK	CILITY E FUN	ERAL	HOME	ct City 21043
d within thous after a property filed in by the i, cremation, or removal event, the medical		23. PART I. Enter the disease, or consider the second shock, or hear fellure. I. IMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that chused it list only one cause on eccl SEPS S DUE TO (OR AS A C	h line.	not enter the mo	de of dying, auc	h aa cardio	oc or reapl	ratory arreat	Approximate interval Between Onset and Death
icate be execute physician and or ie prior to burla er traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF	F):	राष्ट्री				
e death certif the attending Mental Hygier Ijury, or oth	CERT	resulting in death) LAST								
the d M	MEDICAL	PART II. Other significent conditions	contributing to deeth but	not recuiting (in the underlying	g ceuee given in		4a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN: The law requestrificate has been the State Dept. of the State Temps.	SICIAN: 1	DID TOBACCO USE C	CONTRIBUTE TO C	AUSE OF		ES NO				
ertificate h the State I or Item	YSIC	1 YES 2 NO	Inpetiant 2 - ER/Outpeti	ent 3 DOA	OTHER:	e 5 🗆 Rasidenca		Specify)		
NG PHYSII fter this ce eath with t marked,	ВУ РНУ	27. MANNER OF DEATH 1	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM	URY WO	URY AT RK? 'ES 2 NO	28d. DESC	RIBE HOW I	NJURY OCCUR	ED
L OR ATTENDING PORTECTOR: After the hours after death vitem 28 is mark	ETED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm, s	street, factory, office		281. LOCAT City or	ION (Street a Town, State)	and Number or	Rural Route Number,
4 3 5 =	COMPL	onel	EIAN: To the best of my knowled t: On the basis of examination a							ause(e) and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	295. SIGNATURE AND TITLE OF CERTIFIER				3DII	ABER	-	29d. DATE SI	GNED (Month, Pay, Year)
10		39. NAME AND ADDRESS OF PERSON WHO	3468 Eu	COTT	Print)	on Pr	10	3 E	£ /	2020V)
V		DEC 01 1994	32. REGISTRAR'S SIGNATI							

32. REGISTRAP'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow in the float. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.
	1. DECEDENT'S NAME (First, Middle, Last) George Colder 2. DATE OF DEATH MONTH DAY VEAR VOV. 18. 1994
	4. SOCIAL SECURITY NUMBER 5. SEX 1 Social SECURITY NUMBER 5. SEX 1 Social SECURITY NUMBER 1 Social SECURITY NUMBER 1 Social SECURITY NUMBER 1 Social SECURITY NUMBER 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social Security Number 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Vear) 1 Nov. 1 Social
TOR	Dorchester Gen. Hospital Cambridge Dorchester
DIRECTOR	106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 107. INSIDE CITY LIMITS? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
FUNERAL	100. STREET AND NUMBER 526-PINE STREET 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY?
В	11. MARITAL STATUS 1
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
OMP	GRADE CONCRETE FINISHER CONSTRUCTION 15. FATHER'S NAME (First, Middle, Maiden Surname)
BE	HARRY COLDER Ruth Slater 196. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10	Poris Lee Pinder 505 Hubert St. Cambridge, Md. 21613
	20b. PLACE AND DATE OF DISPOSITION DATE 20b. LOCATION - City or Town, State Date
	11. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS-OF FACILITY HENRY FUNERAL HOME 1. SIGNATURE OF FUNERAL HOME
	23. PART I. Enter the diseases, Dr complications that caused the deeth Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):
NOIT	Sequentially list conditions, If any, leading to immediate b. UNLYWED 2 DUE TO (OR AS A CONSEQUENCE OF):
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted evente reaulting in deeth) LAST d
AL	PART II. Other aignificant conditions contributing to deeth but not recuiting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY FINDINGS AMILABLE PRIOR TO
PHYSICIAN: MEDIC	1 U YES 2 INO COMPLETION OF CAUSE OF DEATH?
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 5. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)
YSICI	EXAMINER? 1 YES 2 NO
ву РН	77. MANNER O DEATH 1 Natural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO
8	3 Suicide 8 Could not be 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, streaf, factory, offica building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, streaf, factory, offica City or Town. State)
COMPLET	9a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the cause(e) end manner ee stated.
TO BE	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
	Date FRED MODIT, ON YORK LES ARGUSTIANTS SIGNATURE
	NOV 3 0 1994 Julia Danielon Rarball

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
re funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
f death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
- 8	Joseph WALTER	Cole				November 2	27, 1994	6:02 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a, BIRT	HPLACE (State or Foreign
	218-14-3685 9a. FACILITY NAME (If not institution, give str	1 M 2 □ F 73	YRS.	ONTHS DAYS	HOURS MIN.	APRIL 15,	1921 MA	RYLAND
DIRECTOR	Physicians Memori			La Pl			Charle	
3EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
	MARYLAND CHARL 100. STREET AND NUMBER	ES	NEW	TOWN	ZIP CODE			LIMITS? 1 YES 2X NO
FUNERAL	#8060 BEL ALTON NE	WTOWN ROAD			20646		UNITED	WHAT COUNTRY? STATES
FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES				NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	or No- 14. RAC	E — American Indian, k, White, etc.
BY	3 Wildowed 4 Divorced	FORCES? 1 YES	TESA		2 NO Specif		Spec	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade c	ATION completed)	16a. DECEDENT'S US	BUAL OCCUPATION done during mo.		16b. KIND OF BUS	SINESS/INDUSTRY	DENTOR
ZE.	Elementary/Secondary (0-12)	College (1-4 or 5+)	CONCTO		LIODVED	CONCER	UCTION	
M	7TH GRADE 17. FATHER'S NAME (First, Middle, Lest)		CONSIR	UCTION		ME (First, Middle, Maiden		
	DANIEL COLE					NIE GROSS	-	
BE (19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a		Route Number, City or Tow		
2	MARY HELEN COLE					N ROAD, LA		MD. 20646
	20e, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remon		PLACE AND DATE OF			DATE 20c. LO 12/1/94 LA	CATION — City or T	
			TOKED HEA		D ADDRESS OF FA			TERRIBIND
	MA C. THORN	TON JOHNSON	M00583	THORN	TON FUNE	RAL HOME,		
	23. PART i. Enter the diseesea, or co ahock, or heert failure. Li	emplications that ceused	the death. Do not	enter the mo	de of dying, suc	MARYLAND h as cerdiac or reepi	retory arrest,	Approximate
	IMMEDIATE CAUSE (Final					Α _		Interval Between Onset and Death
	disease pr condition resulting in death)	CEREZ DUE TO (OR AS A	CONSEQUENCE OF):	SCUL	AR .	ACCIDE	NT	
No	Sequentially list conditions, b.	OUE TO (OD AS A						
MI	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS A	CONSEQUENCE OF):					
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST							
AL 0	PART II. Other eignificent conditions			the underlying	ceuse given in	Part I. 24a. WAS AN		. WERE AUTOPSY FINDINGS
DIC.	RENAL	FAIL	URE			1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	HYPERT	ENSI						1 YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI			□ NO □	UNCERTAIN	4 d		
Sic		HOSPITAL:		THER:				
¥	27. MANNER OF DEATH	1 N Inpatient 2 ER/Outp	28b. TIME (6 Other (Specify) 28d. DESCRIBE HOW II	NURY OCCURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y WO	RK? ES 2 NO		TOOM GOODILES	}
	3 Suicide 8 Could not be	26e. PLACE OF INJURY building, etc. (Speci	At home, ferm, atre	et, factory, office		28f. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,
COMPLETED								
API		IAN: To the best of my knowl						
S	2 MEDICAL EXAMINER	: On the basis of examination	and/or investigation,	In my opinion, de	eath occured at the	time, date and place, en	d due to the cause(a) end manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	ngand	la	-	29c. LICENSE NUN		29d. DATE SIGNED	(Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO		TH (ITEM 27) (Type, Pr	int) Route	D-2606 5 & Go1		Road P	0. Box 282
	Vidyasagar Anmang			Charle	otte Hal	l. Marvlan	d 20622	O. DOX 202
	31. DATE FILED (Month, Day, Year) DEC 0 1 199	32. REGISTRAR'S SIGNE	LOT RANGELL					

Į. FOR STATE

REGISTRAR

BALT	death.
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_	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	tificat
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	PIT

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Ella opes Horsey 7:10 November 994 PM 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER t YEAR IF UNDER 24 HRS e. BIRTHPLACE (State or Foreign 1 M 2 F MONTHS DAYS HOURS Virginia 229-09-5252 YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia New Church, Virginia 1 YES 2 NO A CCOMPCK permit. I FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? burial-transit 29187 Innday Driv P.O. Rev

11. MARITAL STATUS

12. WAS DECEDENT EVER IN U.S. FORCES? 1 VES 2

IF YES, GIVE WAR OR DATES 23415

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or If yee, specify-Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: or No. 14, RACE — American Indian Black, White, etc. 2 ANO Never Merried 2 Merried
Widowed 4 Divorced Specify: BY use as the Black ETED. 15. DECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 4 Grade Laborera H.E.Kelly Cannon Factory Farm COMPL notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname Mary Black John Hersey BE 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Top Step Zip Code) 82 19e. INFORMANT'S NAME (Type/Print) 2 Michelle Cepes Church Vo 23415 Lundsay Driv. New pe 20a METHOD OF DISPOSITION
1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Na OATE must ory or other place) the funeral director, Donetion 5 Other (Specify) Nev. 27, Pecemeke City, Md. 21. SKINA UBE OF FUNERAL SSEVICE LICENSEE medicai examiner Heme, 33812 Davis New Church Vo 23415

opt enter the mode of dying, euch ea cerdlec or respiratory arrest, New 21 PART I. Enter the dieeeees, or complications that caused the dehock, or heart fellure. List only one cause on easy line and completely filled in by burial, cremation, or remo Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition In availation stema complicated reculting in deeth) other traumatic event, TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF) prior to If any, leeding to immediate cause. Enter UNDERLYING physician CAUSE (Diseese or Injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initieted events signed by the attending Health and Mental Hygier resulting in desth) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL PERFORMED? shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO certificate has been h the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 Dinpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Realdence 6 Other (Specify) 6 27. MANNER OF DEATH 260. DATE OF INJURY this c 28b, TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED Is marked, 1 Netural INJURY 1 YES 2 NO DIRECTOR: After the hours after death v В Investigation 2 Accident 26s. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Floute Number, City or Town, State) 3 Sulcide e Could not be COMPLETED 4 Homicide 500 item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. THE HOSPITAL (THE FUNERAL D filed within 72 h = 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner se stated. TO THE FUNERA
be filed within 7
IMPORTANT: I 296. SGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 15384 odney 22 94 enrich 2 30. NAME AND ABORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) md 21801 ODNE POWER WENRICH 100 ST. SALISBURY 32. REGISTRAR'S SIGNATURE whi Dandem DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	ξ	
		1. DECEDENT'S NAME (First, Middle, Last) Harry R. Cook , Jr.	2. DATE OF DEATH	3 94	3. TIME OF DEATH
P	7	4. SOCIAL SECURITY NUMBER 192-22-0784 5. SEX 1	7. DATE OF BIRTH (Month, Day, Year) 11-04-30	Court	HPLACE (State or Foreign
2, 3 should	FOR	9a. FACILITY NAME (If not institution, give street and number) Peninsula Regional RESIDENCE OF DECEDENT 9b. CITY, TOWN OR LOCATION OF C Salisbury	DEATH	9c. COUNTY OF	
. Pages 1,	DIRECTOR	Maryland Worcester Ocean City			10d. INSIDE CITY LIMITS? 1 YES 2 NO
020 physician. burial-transit permit. Pages	FUNERAL	10a. STREET AND NUMBER 12308 Old Bridge Road 21842		10g. CITIZEN OF	WHAT COUNTRY?
215-0020 attending physician. ise as the burial-trai	B	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES KOrean 13. WAS DECEDENT OF HISPM If yes, specify Cuban, Maxic	an, Puerto Rican, etc.)	or No- 14. RAC	E — American Indian, ck, White, etc.
T 8 2	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician	166. KIND OF BUS		
YLAND 2 by the hospital be detached to at once.	COMPL	17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S N.	AME (First, Middle, Malden S		
MARY retained b 5 should to	TO BE	19a. IMFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural			
ay be re page 5:	F	Ruth Marie Cook 12308 Pld Bridge Ro 200, METHOD OF DISPOSITION 2016. PLACE AND DATE OF DISPOSITION (Name of		n City,	
MOR ge 6 mi lirector,		1 X Qurial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Maryland Veterans Cem	11/28/04 В		
BALTIMORE, after death. Page 6 may be y the funeral director, page noval. cal examiner must be		21. SIGNATURE OF PHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF F	UNERAL HO	OME Ber	Williams St. lin, MD
hours or rer		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, su- shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final	ch as cardiac or respir	ratory arrest,	Approximata interval Between Onset and Death
		disease or condition resulting in death) . Arteriosclerotic Cardiovascu	lar Diseas	se	years
D 0 3 0	N	Sequentially list conditions b.			
Ze be be	CATIC	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury			
P.O. th certifi anding p Hygien or othe	CERTIFICATION	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.			
In the State of th	AL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Coronary Artery By-Pass, 1979	Part I. 24a. WAS AN A		b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
RECO requires the sen signed of Health	N: MEDIC	Colonaly Altery By-Pass, 1919	1 TYES 2	⊠ NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
VITAL AN: The law Unicate has the State Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XYES 2 NO 1 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Home 5 Residence			
교 등 등 등	РНУ	27. MANNER OF DEATH 28. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK?	28d. DESCRIBE HOW IN	HURY OCCURED	
DIVISION OF OR ATTENDING PHYS DIRECTOR: After this of hours after death with Nem 28 is marked	ED BY	2 Accident investigation 3 Suicide 6 Could not be determined determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	281. LOCATION (Street or City or Town, State)	nd Number or Rural	Route Number,
₹ 4 K =	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end durone) 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the			s) and manner as stated.
TO THE HOSPITAL. TO THE FUNERAL Be filed within 72 IMPORTANT: 11	#	296. SIGNATURE AND TITLE OF CERTIFIER 290. LICENSE NU D0359	MBER	29d. DATE SIGNED	D (Month, Day, Year) -23-94
	2	John T. Bulkeley, M.D., 108 Pine Bluff Rd.	., Salisbu	ary, Md	1. 21801
	12	31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE Juli Sandard Randard			
		V			DHMH-16 Rev 1/89

Amended #1 and #18 11/29/94 T.R.W Allegany County

. DEC	EDENT'S NAME (First,	Middle, Last)						2. DATE O	E DEATH	١
_ S	OR TATE REGISTRAR		STATE OF		DEPARTMENT ERTIFICATE				HYGIENE REG. NO.	
		TI GIIC	λ πιο,	11/25/57		, Allega	, .	count	. 1	

_	1123131111111			<u> </u>	-111111	IVALL	- 01	DLA	111	HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) FREDDIE FREDRICK		T HOMAS			CLARK			2. DATE OF DEATH	4 19	9 ⁴ 4	3. TIME OF DEATH 5:15 P M	
	4. SOCIAL SECURITY NUMBER	9	5. SEX 8. AGE (In yrs. last							7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign	
	216 30 1930	216 30 1930		1X M 2 □ F 63		MONTHS	DAYS	8 HOURS MIN.		(Month, Day, Year) 10/25/31		MARYLAND	
	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY	b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA					DEATH	
DIRECTOR	216 1st S'		r			FRO	OSTI	BURG	i		ALI	EGA	NY
티디	RESIDENCE OF DECE	DENT 0b. COUNTY			Inc. CIT	Y, TOWN C	B 1004	101					
<u>E</u>		ALLEG				ROST							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER					ROSI		. ZIP COD	ODE 100 OIX				1 X YES 2 NO
FUNERAL	216 FIRST STREET						"	21532				A.	WHAT COUNTRY?
3	11. MARITAL STATUS 12. WAS DECEDENT_EVER IN U.S. AR				RMED 13. WAS DECENDE			ENDENT OF HISPANIC ORIGIN? (Specify Yes or No —					E — American Indian,
	1 Never Married 2 Married FORCES? 1X Y			X YES 2 1			f yes, sp	ocity Cuba	n, Mexica	n, Puerto Rican, atc.)	01 110	Blac	k, White, etc.
BY	3 Wildowed 4 Divorce	id	KOREAN C					2,110	ороспу			- Spec	WHITE
	15. DECED (Specify only h	ENT'S EDUC		/G	CEDENT'S	work done o	CCUPATIO	ON st of working	70	16b. KIND OF BUS	INESS/INI	DUSTRY	
9	Elementary/Secondary (0-12	2)	College (1-4 or 5	·) life	. Do NOT us	se retired.)							
COMPLETED	17. FATHER'S NAME (First, Midd		1	FII	TRAT	TON	PLAN						
	II. PAIRER S NAME (FIRST, MICC	re, Last)	EDMA	RD CLARE	,			18. MOTI	HER'S NAI	ME (First, Middle, MST)	ALL	WOO	D
BE	19a. INFORMANT'S NAME (Type	VPrint)	LDWA			ADDDESS	(Stenat a	and Alumbas		ORENCE LUT		0.4.	
2	THOMAS CLARK	,								FROSTBURG,			
	20a METHOD OF DISPOSITION	4		20b. PLACE					1.,				own, State
	1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		oval from Stata	cometery cre	SON	CEME	TERY	•		1			
1	21. SCHATURE OF PUNERAL SERVICE LICENSES. 22. NAME AND ADDRESS OF FACILITY												
	1/1/11/	lou	1 XX	wews)	/					HOME, P.A., FROSTBUR		n 21	532
	23. PART I. Enter the disc	esea, or 6	omplications the	t coused the de	eth. Do r	not enter	the mo	de of dyl	ing, suci	h ea cerdiec or reapi	retory ar	reat,	Approximate
	IMMEDIATE CAUSE (Final		List Drily one cau			2 .		-		0	,	1	Interval Batwean Onset and Death
	IMMEDIATE CAUSE (Final disease or condition resulting in daeth) a. Authoris Classic Condition Condition Conference of: Due To (or as a consequence of):												
1	DUE TO (OR AS A CONSEQUENCE OF):												
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING												
띮	CAUSE (Disease or Injury that initieted events	1	DUE TO	(OR AS A CONSEC	DUENCE OF	F):							-
F	resulting in deeth) LAST	that undated excited											
	PART II. Other eignificent	condition	a contributing to	death but not a	o o ultimo	le the un	و داد داد د		1	Book! Tax making			
EDICAL	Train in Otto agains	CONTONIO	e contributing to	deeth bdt not i	esuning	in the un	deriying	g ceuse (jiven in	Pert I. 24s. WAS AN PERFOR		246	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
										1 YES 2	□ NO	- 1	OF DEATH?
Σ	DID TOPACCO LIST	CONITE	IDLITE TO CA	LICE OF DEA	TIL VE		10 F	1 11116	EDTAIN	. N/			1 YES 2 - NO
AN	DID TOBACCO USI		IBUIE IO CA		E OF DEAT			UNC	ERTAIN	N JA			
PHYSICIAN:	EXAMINER? 1 XYES 2 □ NO		HOSPITAL:			OTHER	t:		7.1				
Ä	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY ÂT	sidenca	8 Other (Specify) 28d, DESCRIBE HOW II	JURY OC	CURED	
ВУ Р	1 Netural 5 Pe	nding estigation	(Month, D.	sy, Year)	INJ	M	1 🗌 1	RK? (ES 2] NO				
	2 Suleide	uld not be	28e. PLACE O	F INJURY — At ho	me, larm, :	street, facto	ory, office	1		281. LOCATION (Street a	nd Number	or Rural I	Route Number,
E		armined	Danoning,	wee. (Specify)					ĺ	City or Town, State)			
7	29a. CERTIFIER	YING PHYSIC	CIAN: To the best of	my knowledge, de	ath occurr	ed at the ti	me, date	and place,	, end due	to the cause(a) and men	ner ea sta	led.	
COMPLETED	CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and menner as stated. Cinck only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated.												
U U	29L SIGNATURE AND TITLE OF CERTIFIER						29c, LICENSE NUMBER			IBER	29d. DATE SIGNED (Month, Day, Year)		
m	Theodo	W	U. Ku	of m	.D.			0	Vicentina and				5,1994
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
	THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201												
150	THEON	100	1-11-4		renr	ST	ree	t, h	3a⊥t	imore. M	arv	Land	21201 I
	31. DATE FILED (Month, Day, Ye)	1/22	the same of the same of	RIS SIGNATURE	Penr	St	ree	t, E	Ba⊥t	imore, M	ary.	Land	21201

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 6

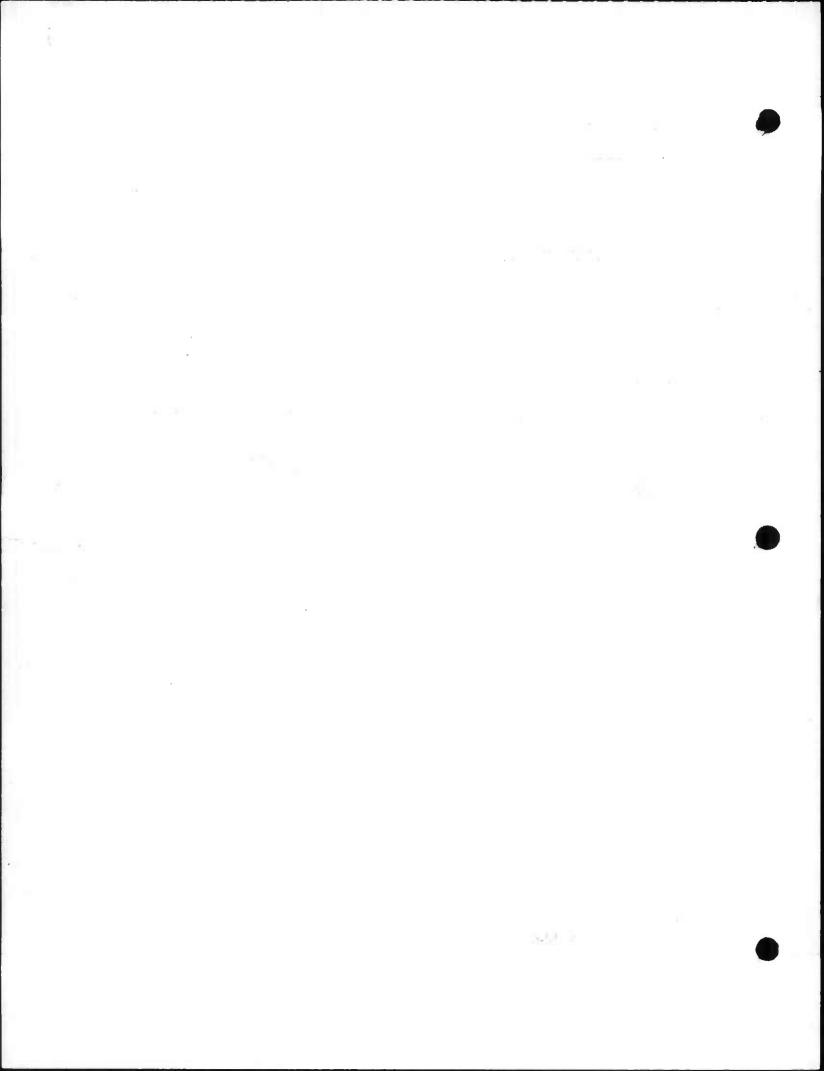
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	REGISTRAR	CERTIFIC	CATE OF	DEATH	REG. NO					
	1. DECEDENT'S NAME (First, MICHIGAL LOSI) PEARL ELIZABETH CARDER 2. DATE OF DEATH NOVEMBER 22 1994 3. TIME OF DEATH NOVEMBER 22 1994 8:05 A									
	PEARL ELIZABETH CARDER	- pin			November 2	.2 1994	8:05 A _M			
	236-14-6535 6635 1 DM 2 (X) F 9:	1 YRS.	F UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1 Ct. 31, 1	903	BIRTHPLACE (State or Foreign Country) WEST VA			
~	9a. FACILITY NAME (If not institution, give atreet and number)	ļ °		OR LOCATION OF DE	EATN	9c. COUNTY				
DIRECTOR	Memorial Hospital		Cumber	land	gany					
Ĕ.	10a. STATE 10b. COUNTY		TOWN OR LOCA				10d. INSIDE CITY LIMITS?			
	MARYLAND ALLEGANY	CUI	MBERLA	ND		1				
BY FUNERAL	624 N. CNETRE STREET		10	21502		10g. CITIZEN OF WHAT U.S.A.				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN UFFORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	It yes, specify Cuban, Maxican, Puerto Rican, etc.)				RACE — American Indian, Black, White, atc. Specify: WHITE			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S US	SUAL OCCUPATION	ON and anothing	16b. KIND OF BU	SINESS/INDUST	'RY			
COMPLETED	Flementary/Secondary (0.12) College (1.4 or 5.1)	(Give kind of wor life. Do NOT use i MACHINE	retired.)				PARTMENT RPORATION			
MO	17. FATHER'S NAME (First, Middle, Last)			18 MOTNED'S NA			KTUKATIUN			
BE C	ELMER SANFORD KECKLEY			MARY	ME (First, Middle, Maiden JANE HAIN	ES				
2	190. INFORMANT'S NAME (Type/Print) RICHARD A. RICHMOND	624 N.	CENT	RE ST-C	UMBERLAN	n, State, Zip Cod D, MD	21502			
	20e. METNOD OF DISPOSITION 1 N Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of capital cr. crematory of righer place) 20c. LOCATION — City or Town, State ROMNEY, WV									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22 NAME A	ADDRESS OF EA	UNERAL H	OME, I	INC.			
-	23 PART I Fiter the diseases, or complications that caused to	the death Do not			O-FT. AS					
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ehock, or heart failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel									
	disease or condition									
ļ	recuiting in death) a. CARD ARCTI DUE TO (OR AS A CONSEQUENCE OF):									
z	Cohons	424 HI	GART	RISCA	56-		Viscas			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. CSASNARY HEART DISCASE DUE TO (OR AS A CONSEQUENCE OF):									
<u>১</u>	CAUSE (Disease or Injury	CONSEQUENCE OF:	6G-							
	that initieted events resulting in death) LAST	ONSEQUENCE OF):								
띩	d									
	PART if. Other significent conditions contributing to death but	not reculting in	the underlyin	g ceuse given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
PHYSICIAN: MEDICAL	DEHADRATION, PS	EUD CME	MBRA	NUL OIL	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
		-		,			OF DEATH?			
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	□ NO E	UNCERTAIL						
Y		8. PLACE OF DEATN	(Check only one)							
is	1 YES 2 NO HOSPITAL:		OTHER: Nursing Hon	e 5 🗆 Residence	6 Other (Specify)					
E	27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year)	26b. TIME (OF 28c. IN.	URY AT	28d. DESCRIBE NOW I	NJURY OCCURE	ED .			
BY	1 Natural 5 Pending 2 Accident Investigation			ES 2 NO						
		28e. PLACE OF INJURY — At home, farm, street, facto building, atc. (Specify)			28t. LOCATION (Street City or Town, State)	N (Street and Number or Rural Route Number, wn, State)				
٦	29e. CERTIFIER (Check only Check only 1 CERTIFYING PHYSICIAN: To the best of my knowled	dge, death occurred	at the time, date	end place, and due	to the cause(e) and med	nner se stated				
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of examination of						use(a) and menner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,									
BE	I Borah	/		D 23334		12/94				
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	'H (ITEM 27) (Type, Pr	rint)				1			
	Dinesh Shah M.D. P.O. Box 131	Pinto, M	D 215.	56						
	Dinesh Shah M.D. P.O. Box 131 31. DATE FILED (MOOTH DAY 2019) 1934 32. HEGISTRAPS SIGNAT				-					



YEAR

9c. COUNTY OF DEATH

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Md.

ALLEGANY

10g. CITIZEN OF WHAT COUNTRY?

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH HARRY EUGENE OVEMBER COLMER 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) April 6 1934 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. MONTHS DAYS 60 YRS. 1) M 2 F 218-30-0735 completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should id. cremation, or removal. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR GREENRICH FORESTOFF JACOB RD FLINTSTONE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Allegany Md Barton FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE P.O. Box 216 21521 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. 48MED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Timberman Lumber Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 100 Paul Colmer BE notified 19a. INFORMANT'S NAME (Type/Print) 2 Jean Colmer pe 20a. METHOD OF DISPOSITION
1 № Burlet 2 □ Cremation 3 □ Removal from must 4 Donation 5 Other (Specify) medical examiner 23. PART I. Enter the diseases, or compile ahock, or heert fallure. List or IMMEDIATE CAUSE (Finel within 24 the disease or condition cremation reaulting in death) traumatic event, executed prior to burial, CERTIFICATION Sequentially list conditions, If any, leeding to immediate ceuse. Enter UNDERLYING that the death certificate be CAUSE (Disease Dr Injury / the attending physidene p or other that initiated events resulting in deeth) LAST injury, PART II. Other algolificent conditions cont PHYSICIAN: MEDICAL Health and N shows any THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires this certificate has been a with the State Dept. of H DID TOBACCO USE CONTRIBUT 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? or Hem HOS XXYES 2 NO TO THE HOSPITAL OR ATTENDING PHYSICIAN TO THE FUNERAL DIRECTOR: After this certif be filed within 72 hours after death with the IMPORTANT. If Item 28 is marked, or 27. MANNER OF DEATH 1 Natural 5 Pending BY

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: White

1X YES 2 NO

8. BIRTHPLACE (State or Foreign

5:05

Colmer		Stella Warnick							
T'S NAME (Type/Print)	19b. MAILING ADDRESS (Street an			ode)					
Colmer	P.O. Box 2	x 216, Barton, Md. 21521							
F DISPOSITION ☐ Cremation 3 ☐ Ramoval from State 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name commetted, grammators, of other place) Mt. V1ew Cem.	ISPOSITION / Name of DATE 20c. LOCATION — City or Town, State							
DEFINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Boal Funeral Home 111 Church St. WEsternport, Md. 2									
nter the diseasea, or complications that can	used the death. Do not enter the mod								
ACUSE (Finel modifier beath) a. DUE TO (OR AS A CONSEDUENCE OF):									
UNDERLYING	AS A CONSEQUENCE OF):								
events DUE TO (OR eeth) LAST	AS A CONSEQUENCE OF):								
er algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO									
ACCO USE CONTRIBUTE TO CAUSI	26. PLACE OF DEATH (Check only one)	UNCERTAIN							
HOSPITAL:	OTHER:		C.C415						
DEATH 5 Pending (Month, Dey, Ye) Investigation	TH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 5 Pending 28a. DATE OF INJURY 28b. TIME OF INJURY AT WORK?								
determined building, etc.	URY — At home, ferm, street, fectory, office Specify)	City	281. LOCATION (Street and Number or Rural Route Number, City or Town, State) OREENRICHTEDRIST OFF JACO 15'S RO ALUGIST						
1 CERTIFYING PHYSICIAN: To the best of my le 2 MEDICAL EXAMINER: On the basis of exemin									
AND TITLE OF CERTIFIERS	29c. LICENSE NUMBER	27 • 1994							
DDRESS OF PERSON WHO COMPLETED CAUSE OF			LNOV						
Month, Day Year) 32. REGISTRANS	111 Pon Stroet	t, Baltimo	re, Maryla	and 21201					
'				DHMH-16 Rev 1/89					

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

COMPLETED

BE

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2 Accident 3 Suicide

4 Homicide

SIGNATURE AND TITLE OF CERTIFIER

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MARYBRION 31. DATE FILED (Month Day NOV

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TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an outside the fact. Page 6 may be retained by the hospital or attending physician.

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1 - FOR STATE REGISTRAR		STATE OF MA	RYLAND	/ DEPART	MENT OF I	HEALTH AND	MENTA	L HYGIEN	E		
1. DECEDENT'S HAME (First	-	and Cue	STANL	EY EDW	ARD CRE	SWELL,JR	2. DATE	OF DEATH	Υ	YEAR,	3. TIME OF DEATH
4. SOCIAL SECURITY HUMB			AGE (in yrs. i		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	3-9	BIRTHE	LACE (State or Foreign
212-26-	2623	1 M 2 - F	65		ONTHS DAYS	HOURS MIN.	(Mon	th. Day, Year)	19	Country)	
9e. FACILITY HAME (If not in					9b. CITY, TOWN	OR LOCATION OF DI		20	9c. COUNT		Land ATH
5226 Fawn (pad			Pyle	esville				Harf	ord
10e. STATE	10b. COUNTY			10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE CITY
Maryland		Harford			E	el Air					LIMITS?
10e. STREET AND NUMBER					10	f. ZIP CODE			10g. CITIZE	N OF WI	IAT COUNTRY?
2114 North						21015				USA	
1 Never Merried 2		12. WAS DECEDENT E FORCES? 1 X IF YES, GIVE WAR	YES 2		If yes, sp	CENDEHT OF HISPAN ecity Cuben, Mexica	n, Puerto	N? (Specify Yes Rican, etc.)	or Ho—	Black,	— Americen Indien, White, etc.
3 Widowed 4 Divo	roed	T TES, GIVE WAR	WWII		I I YES	2 1 HO Specif	у:			Specify	white
15. DEC (Specify only	EDEHT'S EDUCA y highest grade co	TION ompleted)	(Give kind of wo	SUAL OCCUPATI	ON ost of working	161	. KIHD OF BUS	INESS/IHDUS	STRY	*****
Elementary/Secondary (0	l-12)	College (1-4 or 5+)		e. Do NOT use	retired.) Clerk			Mac	hino 1	Fahr	ication
17. FATHER'S HAME (First, M	iddle, Last)				CTELK	16. MOTHER'S HA	ME (Fire)			rabt	ICacion
Stanley Ed	dward C	reswell,	Sr.			unkno		middle, Merderi	Surremen		
19a, INFORMANT'S HAME (7	lype/Print)		1	96. MAILING A	DDRESS (Street	and Number or Rural I	Route Num	ber, City or Town	, State, Zip C	ode)	
Agnes/C. Cre	-			2114	Northri	.dge Driv	e, B	el Air	, Mar	ylan	d 21015
20s. METHED OF DISPOSITI 1 □ Buris 2 M Crematio 4 □ Dogstien 5 □ Other	Div n 3 D Remov	gli frogn State		remetory or othe	DISPOSITIOH (Na		DAT		CATION — CH		
4 Docalision S Dither			R.A.	Ferri	s & Co.	Inc. 1	1/26	/914 We	st Che	este	r, PA
THE MANA	11 17	TAIM						III F	unera.	l Ho	me. P.A.
710000	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd. Abingdon, Md. 21009										
shock, or H	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, abock, or heart fellure. List only one cause on each line. Approximate interval Between										
iMMEDIATE CAUSE (Fin	iel	A. Time	/	*	10.	1					Onset and Death
immediate CAUSE (Finel disease or condition resulting in desth) a. Autuatalistic Caudiavasuriar DUE TO (OR AS A CONSEQUENCE OF): Description b.											
TEATURE DE LA COMPANION DE LA	, b			·			4	Des	in		İ
Sequentisily list conditi if any, leeding to imme	diate	DUE TO (O	AS A CONSI	OUENCE OF):							
cause, Enter UNDERLYI CAUSE (Disease or Inju		DUE TO (DI	PAS A CONS	OUENCE OF):							
that initiated events resulting in death) LAS	т	502 10 (5)	TAS A CDITS	OUENCE OF):							
DART II Osbar dentiles	d.	Howe									1
PART II. Other significe	nt conditions	contributing to de	sth but not	resulting in	the underlyin	g csuse given in	Part I.	24a. WAS AN PERFOR		1	VERE AUTOPSY FIHDINGS WAILABLE PRIOR TO
							-	1 TYES 2	NO		OF DEATH?
DID TOBACCO U	SE CONTRI	BLITE TO CALL	SE OF DE	ATH VEC		UNCERTAIN		/		1	☐ YES 2 1 NO
25. WAS CASE REFERRED TO		BOIL TO CAU.			(Check only one)	JUNCERIAI	עוי			<u> </u>	
EXAMINER?		HOSPITAL:	R/Outpatient		OTHER:	e 5 🗆 Residence	6 🗆 Othe	er (Specify)			
27. MANHER OF DEATH		28e. DATE OF IN. (Month, Day,		28b. TIME (URY AT	28d. DE	SCRIBE HOW IN	JURY OCCU	RED	
	Pending Investigation		-	-	M 1 🗆	YES 2 NO		_			
	Could not be	26e. PLACE OF II building, etc	IJURY At h (Specify)	ome, farm, atre	me, farm, street, factory, office			281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)			
AA- OFFICIED				23							
		AN: To the best of my On the basis of exam									end manner ee stated,
296. SIGNATURE AND TITLE	OF CERTIFIER	0.1				29c. LICENSE NUM			29d. DATE S	IGNED (Nonth, Day, Year)
/ Seehar	all.	Colser	- M	D		OCA	14		· 111	12	3
RICHA	PERSON WHO	T. COL	FF DEATH (IT	M 27) (Type, P)	rint)	201	37	RAPPE	CIN	1401	RUIL RD
31. DATE FILED (Month, Day,		32. REGISTRAR'S	SIGNATURE	1	_		DR L	-1110	UNII	44)	4004
NOV 2	5 1994	Stiles d'an	edin Ro	18-11							

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YEAR

1994

3. TIME OF DEATH 9 45

10d. INSIDE CITY

1 YES 2 1 NO

WHITE

21713

Approximate

Onset and Death

1 day

X

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 NO

12-454

mo 21740

8. BIRTHPLACE (State or Foreign

WASHINGTON

U.S.A.

Specify:

14. RACE — American Indian, Black, Whita, atc.

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	mins after death. Page 6 may be retained by the hospital or attending a
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FOR STATE REGISTRAR

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Section 1	
DIVISION	
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31. DATE FILED (Month, Day, Year) DEC 0 6 1994

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MARY ANN CONNER December 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 1 M 2 X F YRS. 410-74-1669 97 SEPT. 20,1897 NORTH CAROLINA Pages 1, 2, 3 should Ba. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FAHRNEY-KEEDY HOME **BOONSBORO** RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND WASHINGTON **BOONSBORO** permit. FUNERAL 10s. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE burial-transit 5516 AMOS REEDER ROAD 21713 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puarto Rican, atc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY 3 🔀 Widowed 4 🔲 Divorced the 38 COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY USe (Specify only highe ò Elementary/Secondary (0-12) College (1-4 or 5+) 8 HOMEMAKER OWN HOME detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) 2 To FRANKLYN PIERCE CALE JOSEPHINE SANDERLIN BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 CLARA REEDER 5516 AMOS REEDER ROAD, BOONSBORO, MD 9 20s, METHOD OF DISPOSITION
1 S Burlal 2 Cremation 3 S Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, Stata must director, EDGEWOOD CEMETERY 12/7/94 WINDSOR, NORTH CAROLINA 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE SICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY Taul M. 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean led in by the ft. BU Boonsboro, MD filled in by th 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final cremation, the disease or condition resulting in death) myocular the attending physician and completely. Mental Hygiene prior to burial, crematic Aruli Typactie event, DUE TO (OR AS A CONSEQUENCE OF): Antino relate Cardonal traumatic ON Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CERTIFICAT CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL signed by the any de la lacole 1 YES 2 400 reduires Shows has been 10 PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate I HOSPITAL: OTHER: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 YES 2 NO ursing Home 5 - Residence 6 - Other (Specify) the of 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, this c 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident ATTENDING 26a. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 COMPLETED 6 Could not be DIRECTOR: after 28 | 4 🔲 Homicide hours Item OR 29e. CERTIFIER

(Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dats and place, and due to the cause(s) and manner as stated. TO THE FUNERAL DI TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If Ite 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

with mo

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

no

i Dandom Rendoll

2. REGISTRAR'S SIGNATURE

DATTA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

D18014

HACERSTOWN

334 MILL 57

DHMH-16 Rev 1/89

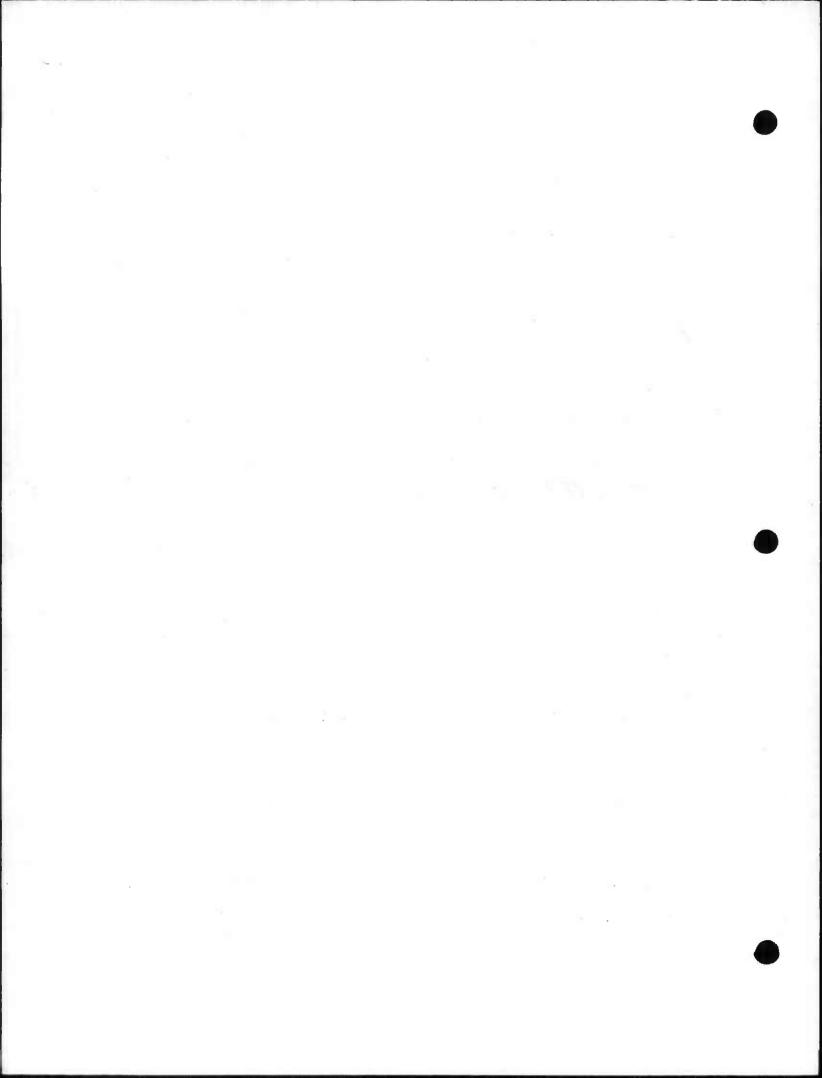
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

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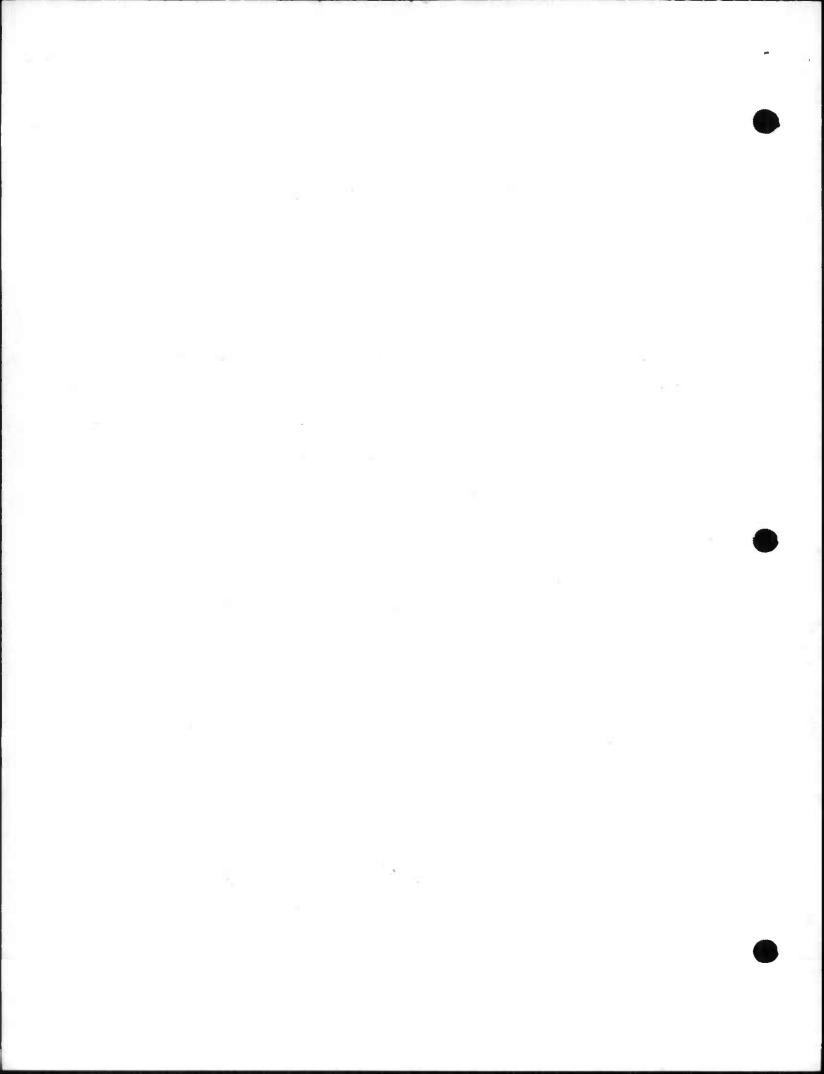
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF CEATH		3.	TIME OF DEATH
	Edward Robert	CUSHEN				DEC	1 19	194 0	2550 Am
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	T	8. BIRTHPL Country)	ACE (State or Foreign
	214-09-4923	July 31 19							land
œ	9a. FACILITY NAME (If not institution, give str				EATH		COUNTY OF DEATH		
DIRECTOR	Washington County	Hager	stown		Washington				
RE	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10	d. INSIDE CITY
		ington	Над	erstown					YES 2 NO
FUNERAL	1.1.0.0.5. The second of the s			101	ZIP CODE				AT COUNTRY?
NE I	11005 Roessner Av	enue 12. Was decedent ever in	IIS ADMED	12 WAS DEC	21740	NIC ORIGIN? (Specify Ye		S.A.	American Indian.
	1 Never Married 2 Married	FORCES? 1 YES	2 ANO	If yea, sp		in, Puarto Rtcan, etc.)	s or No-	Black, V	American Indian; /hita, atc.
BY	3 Widowed 4 Divorced			I I I I I I	2 to NO Specii	y.		Specify: Whit	te
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION completed)	16a. DECEDENT'S US (Give kind of wor	k done during ma		16b. KIND OF BU	SINESS/INDU	JSTRY	
ا ت	Elementary/Secondary (0-12) ()=1 2	College (1-4 or 5+) 1-3	Operatin		wisor	Floor	ric C		
ME	17. FATHER'S NAME (First, Middle, Last)	1-5	operacii	ig bupe		ME (First, Middle, Maider		ompan	У
ŏ	Emmert Earle Cush	en				elle Bragu			1
BE (19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street e		Route Number, City or Tox		Code)	
2	Margaret C. Trade:	r		Lebeck		Hagerstown			21740
	20a_METHOD OF DISPOSITION 1 \(\Delta \) Burlal 2 \(\Boxed \) Cremation 3 \(\Delta \) Ramo		. PLACE AND DATE OF				CATION — C		
	4 Donation 5 Other (Specify)	Ro	ose Hill	Cemeter	y 12-3-	94 Hage	erstow	m. Ma	arvland
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	1	22. NAME A	D ADDRESS OF FA	CILITY Minnic	h Fund	eral	Home
	Dest/1	Illens	uch	415 H	. Wilson	n Blvd. H	agers	town,	Md. 21740
	23. PART I. Enter the diseases, or co shock, or heart fallure. L.	omplications that caused	the death. Do not	enter the mo	de of dying, suc	h as cardiec or resp	iratory arre	est,	Approximata interval Between
	IMMEDIATE CAUSE (Final	LI ALC		A					Onset and Desth
	disease or condition resulting in death)	LVIVG	CAN	CF	8				10/94
		DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR AS A	CONSEQUENCE OF):						
SAT	if sny, leading to immediate cause. Enter UNDERLYING								
Ē	CAUSE (Disease or Injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):						
EB	reaulting In death) LAST								
AL C	PART II. Other significant conditions	contributing to death b	ut not reauiting in	the underlying	cause given in	Part I. 24s. WAS AF	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
						PERFO		CC	AILABLE PRIOR TO OMPLETION OF CAUSE
							- Ano		DEATH?
ä	DID TOBACCO USE C	CONTRIBUTE TO	CAUSE OF	DEATH Y	ES I NO				
PHYSICIAN: MEDIO	25. WAS CASE REFERRED TO MEDICAL			28. PL	ACE OF DEATH (Ch	eck only one)			
YSI	t 🗌 YES 2 🖵 10	HOSPITAL:		OTHER:	a 5 🗆 Realdenca	6 ☐ Other (Specify)			
H	27. MANNER OF DEATH Natural 5 Pending	28e. DATE OF INJURY (Month, Osy, Year)	28b. TIME (WO WO	URY AT RK?	28d. DESCRIBE HOW	INJURY OCC	URED	
B	2 Accident Investigation	20 21 405 05 11 11			ES 2 NO				
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, form, stre :ify)	et, fectory, offic		281. LOCATION (Street City or Town, Stets	end Number o	or Rural Roul	e Number,
COMPLET	29a. CERTIFIER								
MP		tAN: To the best of my knowl							
	296 SIGNATURE AND FILE OF CERTIFIER			m my opinion, o			and due to the cause(a) end manner as stated.		
8	m Jame	an N	1 h		3 3/5	37	29d. DATE SIGNED (Month, Day, Year)		
임	30. NAME AND ADDITION OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P	rint)	0 110	1-	1 / 2	of al	
	1198 KENLY	Ave No	rgerst		md	2174	10		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	0 20].	1.10	OCI . [
	DEC 05 1994	This Denien R	and state						- 1



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within so hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last)	ELT CAR				2. DATE OF DEATH DO NOV 20	YEAR	3. TIME OF DEATH 3:34 A M	
	A CENTRAL MANAGEMENT	8. AGE (In y	8. BIR COU 1904 MAR	THPLACE (State or Foreign ntry) RYLAND					
TOR	CARROLL COUNTY GENE		VESTMIN	R LOCATION OF 0E STER		CARROLL			
DIRECTOR	MARYLAND CARROI	il.		TOWN OR LOCAT IMINSTE				10d. INSIDE CITY LIMITS? 1 YES 2/57 NO	
FUNERAL	100. STREET AND NUMBER 2444 MAYBERRY ROAD			101.	ZIP CODE 2115	58	10g. CITIZEN OF	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U. FORCES? 1 YES IF YES, OIVE WAR OR DATE	2- NO	If yes, spe	ENDENT OF HISPAN polity Cuban, Maxica 2X NO Specify	IIC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	Sp	CE — American Indian, sick, White, etc.	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondery (0-12) 5th	npleted) College (1-4 or 5 +)	Give kind of wor life. Do NOT use i	k done during mos etired.)	st of working	3.7.3.0.7.2.3.3.7.	SINESS/INDUSTRY		
OMI	17. FATHER'S NAME (First, Middle, Last)	F	RODUCTIO	N EMPLA		FOOD CAI			
BE (JOHN		CARL		MARGAI			LONAKER	
5	19a. INFORMANT'S NAME (Type/Print) DONALD M. CARL					Route Number, City or Town		ND 21158	
	20a. METHOD OF DISPOSITION 1 Burles 2 Cremetton 3 Remove 4 Donatton 5 Other (Specify)	I from State cemeter	ACE AND DATE OF	DISPOSITION (Nat	me of	OATE 20c. LO	CATION — City or	Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICEN:		SINTOWN C	22. NAME AN		136 EAS HOME TANI	ST BALTI	MARYLAND MORE STREET MD 21787	
	23. PART I. Enter the diseases, or com- shock, or heert fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	t only one ceuse on each	n line.			n as cardiac or reepi	ratory arrest,	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentially liet conditions, b	CARCINO M DUE TO (OR AS A CO PSEUDOME OUE TO (OR AS A CO RENAL	OF ONSEQUENCE OF): ONSEQUENCE OF):	COL	ON		6 weeks 2 veeks 5 days		
MEDICAL	PART II. Other significent conditione of CAR DIAC ARCOMA (DID TOBACCO USE CONTRIB	CRHYTHM P OF PROSTA	9 ITE			PERFOR 1 TYES 2	MED?	Nb. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26.	PLACE OF OEATH		UNCERTAIN	<u>Ч Ш]</u>			
YSIC	1 🗆 YES 2 🗖 1	OSPITAL: Propertient 2 - ER/Outpette		THEA:	5 🗆 Residenca	6 Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO		28d. DEŞCRIBE HOW II	INJURY OCCURED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY — building, etc. (Specify)	At homa, ferm, stra						
COMPLETED	2001	N: To the best of my knowledg						Vel and manner as stated	
띪	296 SIGNATURE AND TITLE OF CERTIFIER	udomo	ATTENDI PHYSIC	NG	29c. LICENSE NUM			ED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	10 904L	UASH1		POAD	WESTM	WSTER	(2115 CM)	
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU							



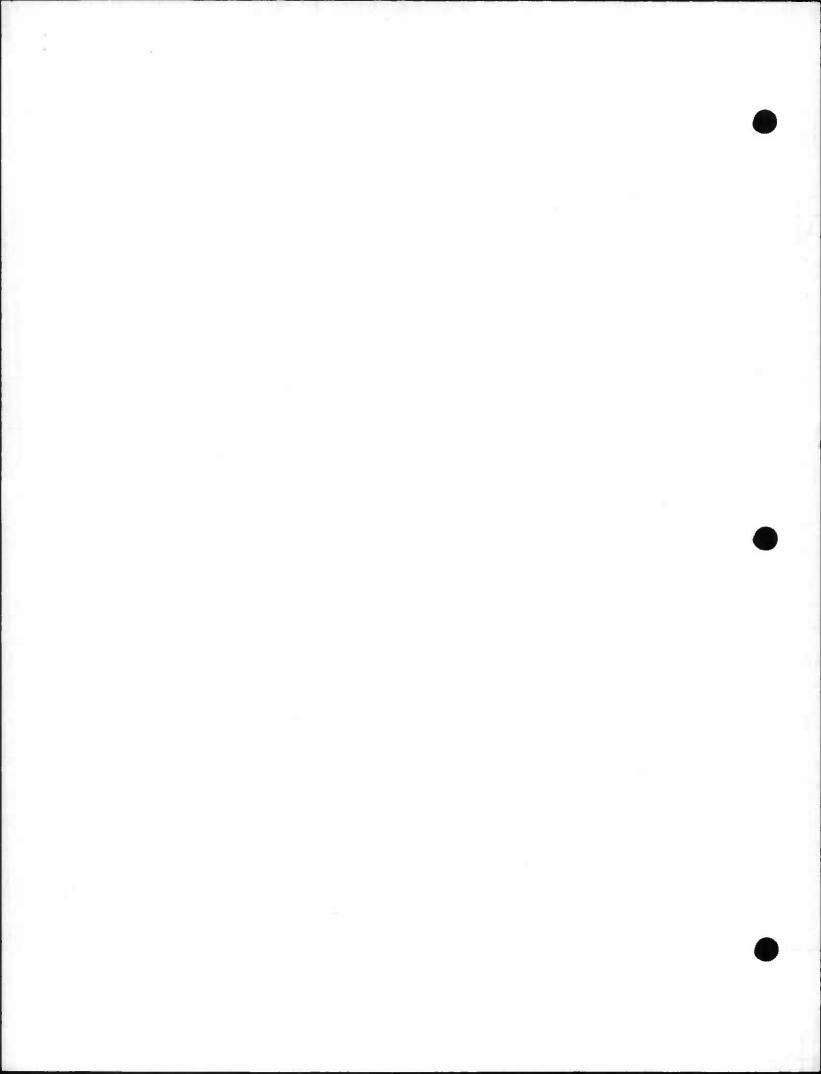
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FOR STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR WINNIE M.

4. SOCIAL SECURITY NUMBER DAVIS 12:25p M NOVEMBER 26 199 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreig Country) DAYS HOURS MIN 1 🗌 M 2 🖵 F 218-36-7637 JANUARY 1902 GEORGIA the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 96. CITY, TOWN OR LOCATION OF DEATH DIRECTOR WILSON HEALTH CARE CENTER <u>GATTHERSBURG</u> MONTGOMERY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO MARYLAND MONTGOMERY GAITHERSBURG FUNERAL 10g. CITIZEN OF WHAT COUNTRY? RUSSELL AVENUE 20877 ours after death. Page 6 may be retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-14. RACE — American Indian, Black, Whita, atc. FORCES? 1 YES 2 NO It yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 TYES 2 NO Specify Specify: BY 3 ₩ Widowed 4 □ Divorced BLACK should be detached for use as COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) be notified at BE HUNTLEY UNKNOWN ROSS MOLLY UNKNOWN WILLIAMS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 CLARENCE DAVIS ELLAMONT ROAD BALTIMORE MARVI AND 2.1.2 5
DATE 20c. LOCATION — City or Town, State page 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Neme of DATE must 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify) 3 - Ramoval from State filled in by the funeral director, netery, cremetory or other place) RRITTIIS /3d/94 BALTIMORE, MD PARK examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FELTON FUNERAL SERVICES, INC Cleans BOX 531351.FORESTVILLE 0. MD20753 other traumatic event, the medical 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, **Approximate** shock, or heart fellura. List only one cause on each line 0 IMMEDIATE CAUSE (Final **Onset and Death** cremation. disease disesse or condition_ B 0 3 FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crematis mic resulting in death) executed with DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, lesding to immediata cause. Entar UNDERLYING 9 the death certificate **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to dasth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED requires that shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES AR. NO 🗆 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one Item **EXAMINER?** 1 YES ZONO STHER: PHYSICIAN: 1 Inpatient 2 ER/Outpatient 3 DOA 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 YES 2 🗌 NO BY Accident HOSPITAL OR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number City or Town, State) 8 Could not be COMPLETED 4 Homicide item ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date TO THE HOSPITAL (
TO THE FUNERAL D
Be filed within 72 h
IMPORTANT: If it (Check only one) 29b. SIGNATURE 29d. DATE SIGNED (Month, Day, Year BE 29c. LICENSE NUMBER 2 MPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 211 RUFFELL AVENUE GAITHERSBURG, MD. 20877 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Devileor Randall 1994 05



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found related to the hospital or attending physician.

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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR			CERTIF	ICALE	: Or	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)			-				2. DATE OF MONTH	DEATH	lγ	YEAR	3. TIME OF DEATH	
		ille Duff						Nov	19		94	10:10A	М
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs		IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D			8. BIRTH Countr	IPLACE (Stelle or Foreign)	ign
	226-03-1493	1 M 2 XF	77	YRS.		- 70		Marc	h 8 1	917	Wes	t Virginia	à
~	9e. FACILITY NAME (# not institution, give street and number)					96. CITY, TOWN OR LOCATION OF DEA							
0	Crofton Convalescent Center				Crofton			Anne Ar			rundel		
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDE CITY	
듬	Maryland Ann	e Arunde	ı		Cri	ofto	n					LIMITS?	0
AL.	10e. STREET AND NUMBER	7 11 01100			011	- T	. ZIP CODE			10g. CIT	IZEN OF W	WHAT COUNTRY?	
ER/	2131 Davidsonville	Road					21114			Un	ited	States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.	ARMED			ENDENT OF HISPAN			or No —	14. RACE	- American Indian,	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W		™			ecify Cuban, Mexica 2 NO Specifi		nn, elc.)		Spec/	₩:	
	7.77											White	
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade		15e.	Give kind of	work done a			16b. Ki	ND OF BUS	SINESS/IN	DUSTRY		
7	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Clei	C17			-	Ru	sines			
\$	17. FATHER'S NAME (First, Middle, Last)			Cle	I N						5		
	Steven Brewster						18. MOTHER'S NA	Jane		,			
B	19e. INFORMANT'S NAME (Type/Print)			19h MAILING	ADDRESS	/Street e	and Number or Rural i				n Codel		
임	Tom Wise						I Court					21054	
	204. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Remo		20b. PLA				me of 11/2				City or To		
	1 Donation 8 Other (Specify)	oval from State	Cemetery.	crematory or o	Nati	onal	Cemete					irginia	
	21. SIGNATURE OF FUNERAL SERVICE CIC	ENSEE		<u>J</u>					s-Rir	naldi	Fune	eral Home	9
	May &	450										Spring, M	
	23. PART I. Enter the disease, or c	pmpiicatione thet	ceused the	deeth. Do r				•				Approximate	
	shock, Dr heert fallure. I	List only one caus	se on each i	line.			ar ay mg, car	. au ouioibi	or roup	atory at	rout,	Interval Bets	ween
	iMMEDIATE CAUSE (Final disease or condition	1/2	10 1	7-0-	0	10	ne					Onset and D	Jeath
ŀ	resulting in death)	DUE TO	OR AS A CON	ISEQUENCE OF	F):								
z		Su	alm.	atr.	1 4	4	ر					į	
2	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CON	ISEOUENCE OF	- -):								
2	cause, Enter UNDERLYING CAUSE (Disease or Injury	o											
	that initiated eventa reaulting in death) LAST	DUE TO (OR AS A CON	ISEOUENCE OF	F):								
CERTIFICATION	readiting in death) Exst	i											
11	PART II. Other significent condition	e contributing to	deeth but no	ot reculting I	n the un	deriying	g ceuse given in	Part i. 24	a. WAS AN		24b.	WERE AUTOPSY FIND	INGS
EDICAL	DHeosclad	tie Con	Dic	للرعد	1c, a	D	Janes	2 .	PERFOR			AVAILABLE PRIDE TO COMPLETION OF CAU	
									_ 123 2			OF DEATH?	
ž	DID TOBACCO USE CONTR	RIBUTE TO CAL	USE OF D	EATH YE	S 🗆 N	10 E	UNCERTAIN	101					
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			LACE OF DEAT	'H (Check o	only one)							
ğ	1 YES 2 XNO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	4 X Nurs		e 5 🗆 Residence	8 Other (S	pecify)				
E	27. MANNER OF DEATH	28e. DATE OF I		28b. TIM	E OF URY	28c. INJ WO	URY AT RK?	28d. DESCR	BE HOW I	JURY OC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 NO						
	3 Suicide S Could not be	28e. PLACE OF building, a	INJURY - Al	home, farm, a	treel, facto	ory, office	•	28f. LOCATIO	ON (Street e own, State)	nd Numbe	r or Rural R	loute Number,	\neg
	4 Homicide determined												
	290. CERTIFIER (Check only	CIAN: To the best of r	my knowledge,	, death occurre	d at the tir	me, date	and place, end due	to the cause(s) end men	ner as ata	ted.		
COMPLETED	one) 2 MEDICAL EXAMINER											end manner es state	ed.
BEC	296. SIGNATURE AND TITLE OF CERTIFIER	0.	<u> </u>				29c. LICENSE NUN			29d. DAT	E SIGNED	(Month, Day, Year)	\neg
	1197 BMood	my M		-DCA	,		D1475	53		►N.	ovem	ber 28, 1	994
2	30. NAME AND ADDRESS OF PERSON WHO								_				
	Robert Kroopnic					ad	Suite 2	203 GI	en Bı	ırnie	, MD		
	31. DATE FILED (Morith, Pay, Year) 1994	32. MEGISTRAE	S'S SIGNATUR	Rando 00									
	1101001004	1	(100) (- 1

Eleanor

5. SEX

CERTIFICATE OF DEATH

8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

Dickinson

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Anna

4. SOCIAL SECURITY NUMBER

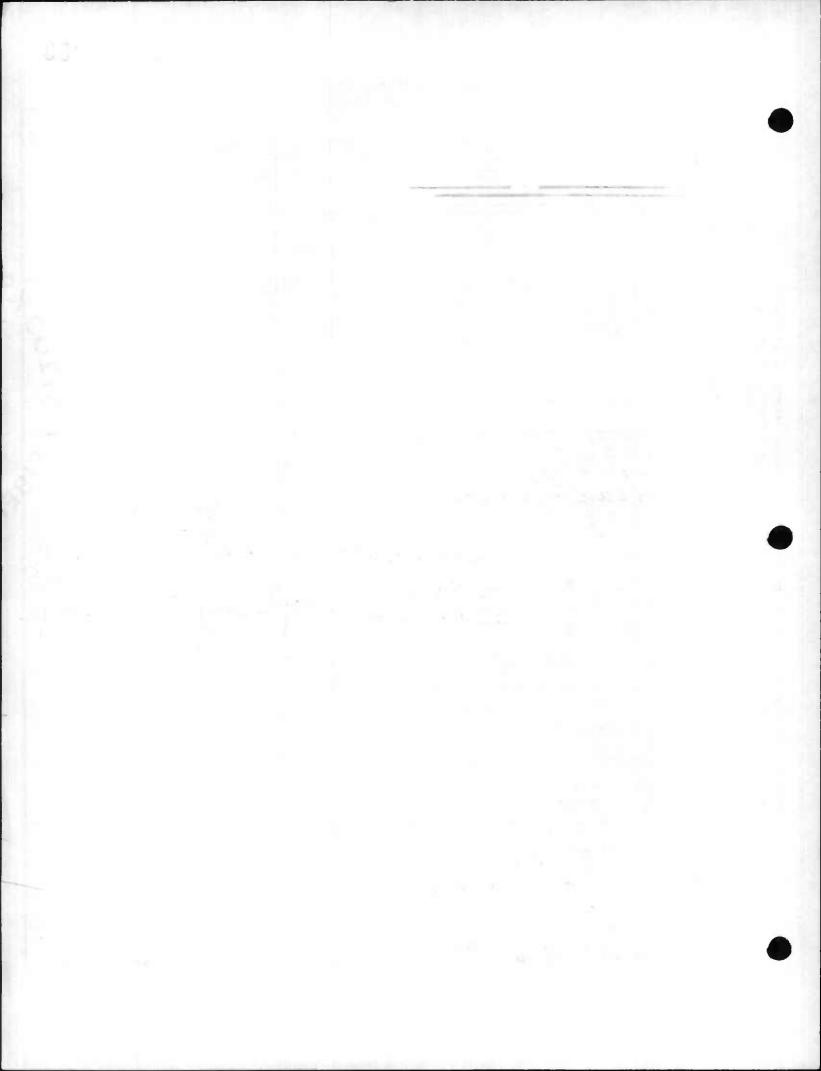
31. DATE FILED (Month, Day, Year)

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E C	RESIDENCE OF DE	10b. COUN	YTY		1	10c. CITY, TOWN OR LOCATION						10d. INSIDE CIT		
	Maryland	Mon	togmer	У		Rockville								LIMITS?
FUNERAL	10a. STREET AND NUMBER		10f. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY						
NE	1235 Potomac Valley Road 20350 U. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14.)									USA				
BY	3 ★ Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES ★ NO Specify:										American hita, atc. WHII			
150	15. OE (Specify on	CEDENT'S EC	DUCATION ide completed)		(Give	DENT'S USUAL	ne during i	TION most of working	g		KIND OF BU			
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BE C	George	н.	Agnew						Mar		Corco	,		
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	20s. METHOD OF DISPOSIT	on 3 🗆 Ra	moval from Sta			DOATEOF DISP story or other place (etown)			. la	DATE	20c. LO	CATION - C	Olty or Town,	State
- 19	4 № Donation 5 □ Other		LICENSEE	2	seorg		2. NAME	AND ADDRES	S OF FAC	II ITV				
	. //	. 1	41	1.0			Aus	tin F	Roys	ter				
\vdash	Ten	upt	1.0	UT	ti-		360	5 141	ch S	t. I	V.V.	Wash	DC	. 2
	2 PART L Enter the c shock, or i IMMEDIATE CAUSE (if disease or condition resulting in death)	reget fallure	r complication s. List only on	a that cause e cause on o	ed the death each lina.	h. Do not ent								Appro
TIFICATION	shock, or i IMMEDIATE CAUSE (FI disease or condition resulting in death) Sequentially list condi- if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inji- that initiated events	tions, ediate	a. List only on	a that cause e cause on de cau	A CONSEQUE	ENCE-OF):								Appro
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32. REGISTRAR'S SIGNATURE
Funda Davidson-Randage

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH 3. TIME OF GEATH YEAR 11/06/1994 4:00A 7. DATE OF BIRTH (Month, Day, Year) 3/18/1909 8. BIRTHPLACE (State or Foreign California ATH 9c. COUNTY OF DEATH Montogmery 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, atc. IC ORIGIN? (Specify Yes or No-, Puerto Rican, atc.) Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY Montogmery Co. Public School AE (First, Middle, Malden Sumame) Corcoran oute Number, City or Town, State, Zip Code) 20008 Ave, N.W. #203, Wash, DC DATE 20c. LOCATION — City or Town, State 111/6/94 Washington, DC. ter Funeral Home t. N.W. Wash, DC. 20010 as cardiac o reapiratory arrest, Approximate Interval Between 24a. WAS AN AUTOPSY PERFORMED? Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 1 | YES 2 | NO ck only one) Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (FIRST, MIDDIE, Last)		1	- 1	2. DATE OF DE	DAY) YEAR	. TIME OF DEATH		
	CHARLOTTE E. DO		-			0/ 9	4	12 = A M		
	0.60 40 6044	est birthday) IF U	THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day,	Year)	Country)	ACE (State or Foreign		
	U62-12-2241 1		CITY TOWN O	R LOCATION OF DEA		, 1909	NEW	York		
DIRECTOR	Hebrew Home	1	Rockvi		AIR .	7.	ntgom			
EC	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY			
L DIF	Maryland Montgomery 100, STREET AND NUMBER	Silver Spring					LIMITS? 1 YES 2X NO 10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	106 East Indian Spring Drive	20901					tates			
B≼	11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 ☐ YES 2 ☑ IF YES, GIVE WAR OR DATES						or No 14. RACE — American Indian, Black, White, atc. Specify: White			
	(Specify only highest grade completed)	DECEDENT'S USUA Give kind of work of	fone during mos		16b. KIND	OF BUSINESS/IN				
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	nemaker		Home						
00	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAM	NE (First, Middle,	Maiden Surname)				
BE	Evan Richard Evans			Charlot			Ro	SS		
6		igh. Mailing add Same as		nd Number or Rural R	loute Number, Cit	y or Town, State, Zi	p Code)			
	20a. METHOD OF DISPOSITION 20b. PL ACE	E AND DATE OF DIS		me of	DATE	20c. LOCATION —	City or Town	n. State		
	1 XBurial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify)	rematory or other p	llev Co	emetery 4	-21-95	Granvil	le. N	Y		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AN	Funeral S	WITY YELD					
	2011 /3/4/ MOI	0827		ist Ave,				20910		
	23. PART I. Enter the disesses, or complications that caused the d shock, or haert failure. List only one cause on each ile	feath. Do not e	nter the mo	de of dying, auch	an cerdiec o	r raspiratory as	rest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	0F 7	HE A	LZHEI	MER'S	TYPE		Onset and Desth		
N	Sequentisity list conditions,									
AŢ	if any, leading to immediate csuse. Enter UNDERLYING	NSEQUENCE OF):								
음	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONST	EQUENCE OF):								
題	reaulting In death) LAST									
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EDIC					1 🗆	YES 2 NO	0	OMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO									
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	OT	26. PL	ACE OF DEATH (Che	ck only one)					
IYSI	1 VES 2 NO 1 Inpatient 2 ER/Outpatient 27. MANNER OF DEATH 28s. DATE OF INJURY	3 DOA 4	Nursing Hom	5 Reeldence						
	Natural 5 Pending (Month, Day, Year)	28b. TIME OF INJURY	28c. INJI WO M 1 7		28d. DESCRIBE	HOW INJURY OC	INJURY OCCURED			
D BY	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At h building, etc. (Specify)	nome, farm, street				(Street and Numbe	r or Rural Ros	ute Number,		
	4 Homicide determined				City or Tow	n, State)				
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, of medical examination and/or							and manner se stated.		
BE C	296. SIGNATURE AND THE OF CRATIFIER			29c. LICENSE NUM				Month, Day, Year)		
10 B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED BALLSE OF DEATH (IT.	con	1	D 180	176	> /	12/1	194		
	D.D. PATEL, W.J. 6121	MON	TRO.	se Ro	Roger	VILLE A	uD z	0852		
	31. DATE FILED (Month, Day, Year) DEC 0 2 1994 22. REGISTRAR'S SIGNATURE	æ		7	- 14.	,				
	DHAID									

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	. DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

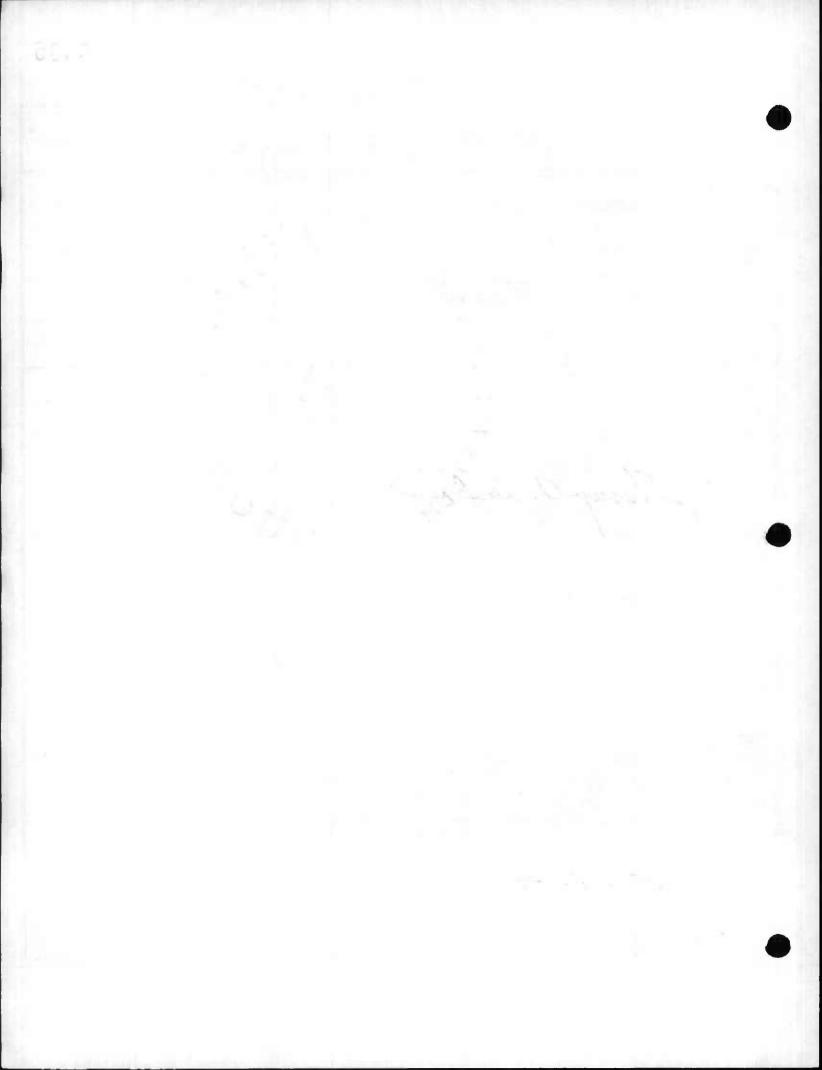
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

REGISTRAR 1. DECEDENT'S NAME (First, Middle, I			ERIT	CAIL	OF DEATH	1	REG. NO.			15		
						2. DATE			YEAR	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER	uBusky 5. sex	8. AGE (In yrs. I				11	/	994		11:40P		
577-1.8-9092	1 M 2 A F	7 4	YRS.	MONTHS	DAYS HOURS MIN	(Mon	OF BIRTH h, Day, Year)	220	Countr	**		
9e. FACILITY NAME (If not institution,	9a. FACILITY NAME (If not institution, give street and number)					DEATH	/25/1			hington, D		
Manor Care Nursing 600 LargoRd Largo Prince Georg												
10a. STATE 10b. CO		ranc		,	R LOCATION				10d. thSIDE CITY LIMITS?			
	LICE GEO.	Lyes	Largo 101. ZIP CODE					10q, CIT	ZEN OF V	1 ₹ YES 2 NO		
100. STREET AND NUMBER 600 Largo Ro	ad				2077	2						
11. MARITAL STATUS	12. WAS DECEDE	ENT EVER IN U.S.		13. W	AS DECENDENT OF HIS	PANIC ORIGI	N? (Specify Yea	or No-	US 14. RACE	E - American Indian		
3 Widowed 4 Divorced		1 YES 2 WAR OR DATES	.]NO	H	yes, specify Cuben, Mer	ican, Puerto icliy:	Rican, etc.)		Black	WHITE		
15. DECEDENT'S (Specify only highest Femorary/Secondary, (0-12) / th Grade 17. FATHER'S NAME (First, Middle, Las Harry, Blance	EDUCATION grade completed)	16a. I	DECEDENT'S	USUAL OC	CUPATION	164	. KIND OF BUS	SINESS/INC	USTRY			
Elementary/Secondary (0-12) /th Grade	College (1-4 or t)+)			uring most of working		_03					
			comes	tic	Clerk		Peop	les	Dru	g		
17. FATHER'S NAME (First, Middle, Las Harry Burns				i i	18. MOTHER'S		Middle, Maiden Ruck					
19a. INFORMANT'S NAME (Type/Print) Fran Maybe	19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State												
4 Donation 8 Other (Specify)		- George	cremetory or ot	her place)	ied. Scho		11/91	Ta7 = C	li fin	aton DC		
21. SIGNATURE OF TUNERAL SERVICE	CE LICENSEE		-9000		ice being	CHIL	/ 7/ / / 2	was		GLOHEDLA		
					AME AND ADDRESS OF							
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H /	or complications the	nat caused the cause on each lie	desth. Do n	Αυ 36	stin Roy	ster St.	J.W. T	Wash	.DC	20010 Approximate Interval Batween		
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Stephanie Trifoxlio, MD 7500 Greenway Center Dr. Greenbelt, MD20770

1994

32. REGISTRAR'S SIGNATURE
June Davidson-Randalle



3. TIME OF DEATN

8. BIRTNPLACE (State or Foreign

IVY,

MONTGOMERY

USA

14. RACE — American Indian, Black, White, atc.

Specify: BLACK

6:27A

VIRGINIA

10d. INSIDE CITY

1 X YES 2 NO

Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS

AWAILABLE PRIOR TO

1 YES 2 NO

COMPLETION OF CAUSE OF DEATH?

REG. NO

FOR

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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PPS

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31. DATE FILED (Month, Day, Year)

NOV29

1994

2. DATE OF DEATH Trancis)orseu NOVEMber 7. DATE OF BIRTH (Month, Day, Year)
JUNE 6, 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (in vrs. last birthriay) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 X M 2 - F 28-1685-61 78 YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c CITY TOWN OR LOCATION MARYLAND PRINCE GEORGE'S LANDOVER permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? be detached for use as the burial-transit 6808 EL PASO ST. 20785 retained by the hospital or attending physician. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3XXWidowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16h. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5+) PVT. 12th CUSTODIAN 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) SADIE SOUTHALL BEN DORSEY 76 BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SADIE VENABLE 6808 E1 PASO STREET LANDOVER, MARYLAND 20785 / DAUGHTER ag å 20a. METNOD OF DISPOSITION
1 A Burial 2 Cremation 3 Removal from State Раде 6 тау 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must HARMONY MEMORIAL PARK 12-3 4 Donation 5 Other (Specify) LANDOVER, MARYLAND 21 SIGNATURE OF FUNEDAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS CENTRINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND the medical 23. PART i. Enter the disesses, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, filled in by shock, or heert failure. List only one ceuse on each line. 6 IMMEDIATE CAUSE (Fine) cremation. the disesse or condition completely resulting in death) event. executed in and com to burial, traumatic CERTIFICATION Sequentisity list conditions, if sny, leeding to immediate DUE TO (O AS A CONSEQUENCE OF the attending physician I Mental Hygiene prior to certificate be . Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO TOTAL A CONSEQUENCE DF): that initiated events resulting in deeth) LAST 6 PART_II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY been signed by the PERFORMED? that any 1 TYES 2 TINO requires DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO OR ATTENDING PHYSICIAN: The law has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) tem THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate I fled within 72 hours after death with the State HOSPITAL OTHER: 1 YES 3 10 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 28 4 Nomicide detarmined Ē Item CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as stated. COMPL -PORTANT ATURE AND TITLE DE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mogth, Day, Year)

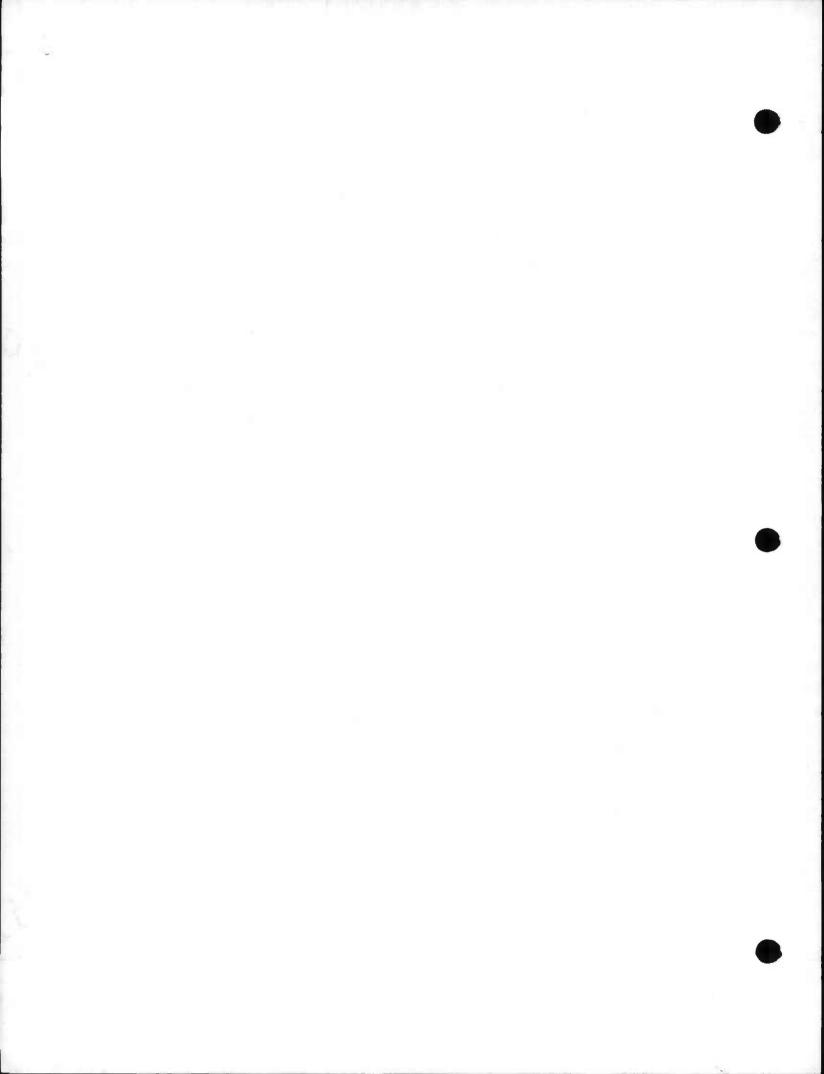
ENNIS

32. REGISTRAR'S SIGNATURE

na Daydon-Mandell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - STATE REGISTRAR	STATE OF N		/ DEPAI ERTIF					MENTAL HYGIEN REG. NO.					
		1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DA		WEAR	3. TIME OF DEATH	_	
	1	Lewis J	Dona									94	0150	A	
		4. SOCIAL SECURITY NUMBER 579-58-2249	5. SEX	6. AGE (In yrs. Ia	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)	_	Country	PLACE (State or Foreign		
pinou		9a. FACILITY NAME (If not institution, give		47	THO.	9b CITY	TOWN	D I OCATI	ON OF DE	6.11.42		WAS	HINGTON,	, 1	
2, 3 should	DIRECTOR	WASHINGTON ADV		HOSPITA	AL	,		A P.							
s 1, 2		RESIDENCE OF DECEDENT			MONIGOMERY										
Page	DIRE	NARTILAND 106. COUNT								10d. INSIDE CITY LIMITS? XXYES 2 NO					
permit		10e. STREET AND NUMBER			101. ZIP CODE 10g. CITIZEN OF WHAT COU										
ansit	FUNERAL	6500 RIGGS ROA	.D								l	J.S.	Α.		
physician. burial-transit permit, Pages 1,	J.	11. MARITAL STATUS KX Never Married 2 Married	12. WAS DECEDEN FORCES? 1	YES X	RMED NO					IC ORIGIN? (Specify Year, Puarto Ricen, atc.)	or No	14. RACE Black,	- American Indian, White, atc.		
the the	ВУ	3 Widowed 4 Divorced	IF YES, GIVE W	MAR OR DATES			t 🗌 YES	Ž√.XNO	Specify	•		Specify	BLACK		
attending use as the	TO BE COMPLETED	15. DECEDENT'S EDU (Specify only highest grad		- (0	ECEDENT'S	work done	CCUPATIO	ON st of workin	19	16b. KIND OF BUS	INESS/IND	USTRY			
oftal or of for u		Elementary/Secondary (0-12)	College (1-4 or 5 -	·)	B. DO NOT L HOUS		EPTN	IG.		PRI	IVATI	E			
the hospital or attend detached for use as once.		17. FATHER'S NAME (First, Middle, Last)				210			HER'S NA	ME (First, Middle, Malden	Surname)			_	
3 E &		JAMES DONALDSO	N					WI		E MAE BUI		DΕ			
s should 5 should notified		19a. INFORMANT'S NAME (Type/Print)	/ O T O M P D							Noute Number, City or Town		Code)			
6 may be ctor, page		SARAH SAMSON	(SISTER	_	1332				1,	N.E.; WD					
		1X Buriel 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	20b. PLACE cemetery, cr H A R M		44 .4 1			К.	12/1/94 1	CATION — C	-			
		21. SIGNATURE OF FUNERAL SERVICE LI			ONI	22.	NAME AN	D ADDRE	SS OF FAC	YTHE				-	
0 = 0		→ Gendan	Men	ank						ENKINS FU STREET,					
ours after of in by the or removal.		23. PART I. Enter the diseases, or ahock, or heart feilure.	complications tha	t ceused the d	eeth. Do	not enter	the mo	de of dy	ing, such	as cardiac or respi	ratory arm	est,	Approximate		
		IMMEDIATE CAUSE (Fine)	N A	- A L A	11	10	hr	1.1	1111				Onset and De		
completely ial, crematific event, the		disease or condition resulting in death)	NO TO	AUM	MI	W	W	VYV	WIL	<i></i>			Igan		
executed within 25, and completely filled to burial, cremation, the matic event, the	_	_	his	In	M	W)	1/4/	1/1	MU	U.			ILLA		
e be execute sician and c orior to buria traumatic	101	Sequentially list conditions, if any, leading to immediate	(Sue to	TON AS A CONSE	OUENCE O	3 1	3	VV	-0	/			9 11		
cate b shysicii e prio	S	CAUSE (Disease or injury											240	L	
eath certificate be a attending physician ntal Hygiene prior to y, or other traun	CERTIFICATION	that initiated events resulting in deeth) LAST	ROLL	MA	IM	M	WN	1 d	MI	Urh ST	rol	m	Umm	1	
the attend Mental H		PART II. Other significant dondition	de contributor to	death but and		In the co	al a al a la a		T/	200	1	Lase	B11.1.10		
1 20 T	CAL	AMELITY	mon	CAT	177	MI	MA	MI	W	PERFOR	MED?	1	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE		
	AED	7		100	~		/	1.		T 1 VES 2	H-NO		OF BEATH?		
he law requires tha thas been signed I bept. of Health a m 23 shows any	N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES. NO UNCERTAIN													
ID THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires ID THE FUNERAL DIRECTOR: After this certificate has been significate within 72 hours after death with the State Dept. of Heat MPONTANT: It Item 26 is marked, or Item 23 shows:	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEA	TH (Check								_	
PHYSICIAN: The this certificate h with the State I with the Mate I when the state I when the state I when the state I when the state I when the state I when the state I will be state I will will be state I will be state I will be state I will be state I	PHYS	1 YES 2 HO	1 Stripetient 2 C		28b. TIA	_	sing Ham 26c, INJ	-	reidence	8 Cl Other (Specify) 26d, DESCRIBE HOW II	HILLIAN OCC	umin.		_	
NG PHYS fer this c eath with marked,		1 Natural 5 Pending	(Month, D			JURY	WO.	RIK7	NO	and, DESCRIBE HOW II	DUNY OCC	UNED			
R: After r: death	ED BY	3 Suitide 6 Could not be	28s. PLACE O building.	F INJURY — At hi	ome, farm,	street, fact	ory, office			28f. LOCATION (Street a City or Reen, State)	nd Number i	or Hunel Ac	tote Number,	_	
DR ATTENDING DIRECTOR: After hours after death		4 Homicide determined		100											
TAL DR A AL DIREC 72 hours If item	COMPLET									to the cause(s) and man					
HOSPITAL FUNERAL WITHIN 72 H	00	2 MEDICAL EXAMINI	++	rangination and/or	Investigati	on, in my	pinion, di	eeth occur	ed at the t	time, data and place, an	f due to the	s zenee(a)	and manner as atmed.	_	
TO THE HOSPI TO THE FUNER OF FREE WITHIN	BE	23E SIGNATURE AND TITLE OF GERTIFIE	MM/U	$\forall M$	M	1	V	39-1100	S II	A G	DATE DATE	DIONED!	TON J'er		
₽ P R M	2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type	o, Print)	277	4	214	N.	- 1	1	1 7 7	_	
0)		DR. LEWIS	DENN	ris											
		31. DATE FNOW 300 000 1994	32. REGISTRA	Day down	fandel	2									
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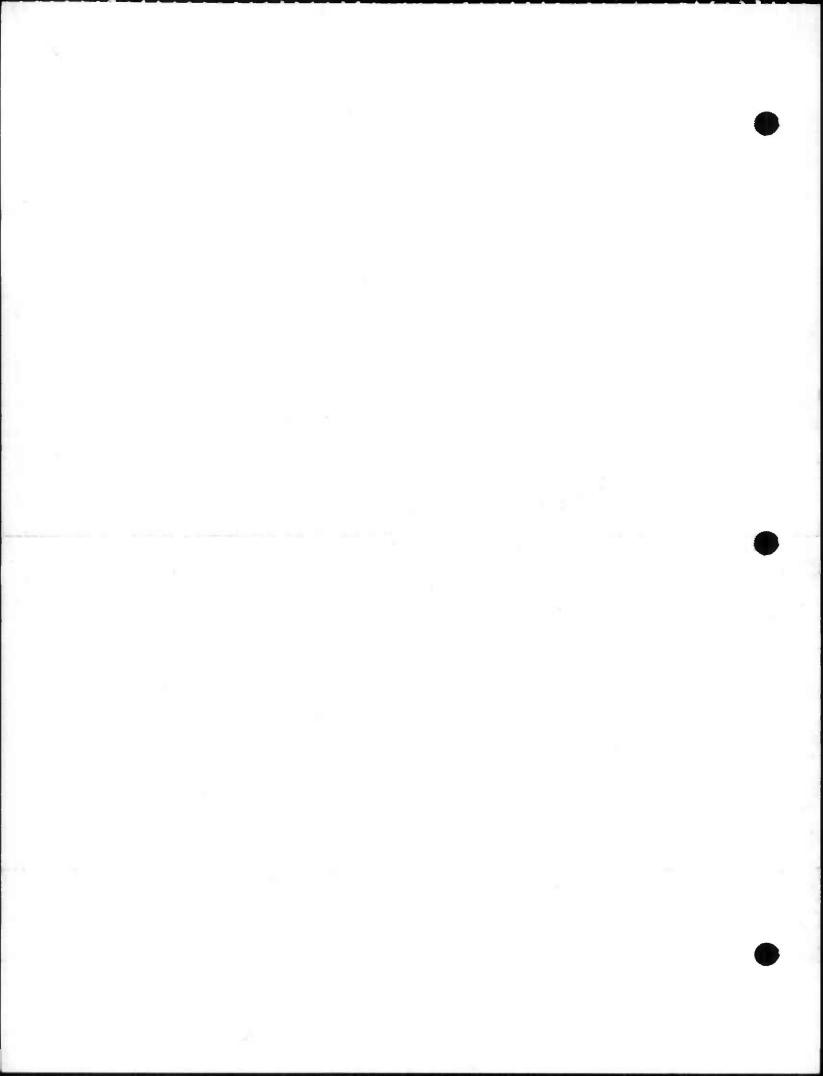
DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the near heads. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

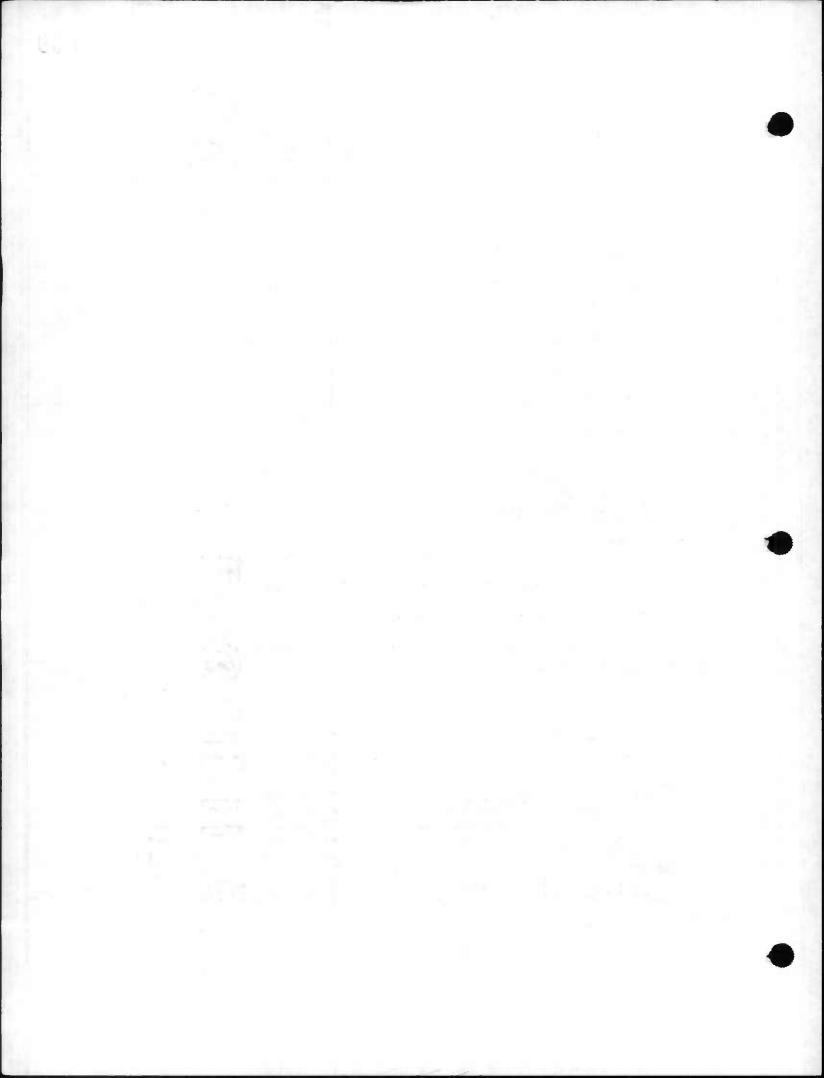
	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF I		MENTAI	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH			3. TIME OF DE	EATH	
Total St.	VINCENT JAMES 4. SOCIAL SECURITY NUMBER 5	DAFFAN Sex Sex		IF UNDER 1 YEAR		+	ember :	25, 1		2:40	А м	
		6. AGE (//	yrs. lest birthday) YRS.	HOURS MIN.	(Afanth On Man)							
. 1	9a. FACILITY NAME (If not institution, give stree	et end number)		9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUN	TY OF DE	ATH		
DIRECTOR	11-A Hillside Road	d		Green	belt .			Prin	nce (George	s	
Œ	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION					10d, INSIDE CI	TY	
	Maryland Prince	George's	Gre	enbelt						LIMITS?		
RA	11-A Hillside Road	1		10	20770					HAT COUNTRY	?	
FUNERAL		C. WAS DECEDENT EVER IN	II.C. ADMCD	40 110 05	ENDENT OF HISPA			U.S.				
	1 Never Merried 2 Married	FORCES? 1 YES	2 X NO	II yes, sp	r? (Specify Yes Rican, etc.)	or No-	Black	— American in White, etc.	idlen,			
BY	3 Widowed 4 Divorced	IF 1ES, GIVE WAR ON DA	1 L YES	2 ∰ NO Specif	ry:			Specif.	r Caucasi	an		
E	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION (mpleted)	16a. DECEDENT'S U	ISUAL OCCUPATI	ON	16b.	KIND OF BUS	INESS/INDI		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use	retired.)	ist or working							
MP	0	. 4 1			N/A							
8	17. FATHER'S NAME (First, Middle, Last)	D 66			18. MOTHER'S NA							
BE	George Carmichael	Dattan			Lisa Ma	arie	Gibson					
5	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural				,	0077/		
	George C. Daffan		11-A H	lillside	Road, G	reen				20770	,	
	20a. METHOD OF DISPOSITION 1 Burlal 2 □ Cremailon 3 □ Ramova 4 □ Donation 5 □ Other (Specify)	ol from Stata 20b.	PLACE AND DATE OF the control of the	eenbelt, Maryland								
	21. SIGNATURE OF FUNERAL SERVICE LICEN		CCHOCIC	22. NAME A	ND ADDRESS OF FA							
Francis Gasch's Sons Funeral Ho												
	23. PART i. Enter the diseases, or con	npilcations that caused	tha death. Do no	ot entar tha mo	da of dying, suc	h sa card	lac or raapi	ratory arre	eat,	Approxi		
	shock, or heart failure. Lis	it only one cause on as	ch lina.								Bstwesn nd Daeth	
	disease or condition resulting in desth)	Metast	alia Pr	in Live	Deura	and for	lama	10	1 440 0/	- 1	en/	
	immediate CAUSE (Final disease or condition resulting in death) s. Metastatic Trimitive Neurocotodamnol Tumor Tyear DUE TO (OR AS A CONSEQUENCE OF): Sequentisily list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):											
ž	Someontielle liet ecoditates D.	Respirate	y Comp	romisc	Secon	dar	y to	Tun	~0~	3 m	ouths	
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING											
<u> </u>	CAUSE (Disease or Injury C.	DUE TO (OR AC A	CONSEQUENCE OF)							-		
	that initiated events resulting in death) LAST	DOE TO (OH AS A	CONSCOUENCE OF)							j		
岂	d									-		
AL.	PART II. Other significant conditions of	contributing to death bu	it not reaulting in	the undarlyin	g causa given in	Part i.	24s. WAS AN PERFOR			WERE AUTOPSY		
ջ							1 YES 2			COMPLETION O		
								31		OF DEATH?	(NO	
ž	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES	ON D	L UNCERTAI	N 🗆					`	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	8. PLACE OF DEATH									
Ž Į		☐ Inpetiant 2 ☐ ER/Oulpe		OTHER: Nursing Hore	Residence	8 🗆 Other	(Specify)					
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. IN.	URY AT	28d. DE\$	CRIBE HOW IF	JURY OCC	URED			
À	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆								
<u>a</u>	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Specia	— At home, larm, str y)	reet, lactory, offic			BI. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
91	29a. CERTIFIER	//	7,000-7300000					_				
COMPLET		o the best of my knowle On the basis of exemination								and manner as	stated.	
	29h SHATUAE AND TITLE OF CERTIFIER				29c. LICENSE NUI						1	
BE	119114M/12	All . 1.	Pl	O. m.	MD_ DA	421	35	DATE	A/	Month, Day, Yea	<i>(1)</i>	
임	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEA		Cian.	110-17	100	20	00	IVO	0 1		
	Depart ment of Hem	stology/Oncolo	ogy Child	1 / / /	i enal Med	ical6	enter,	Wash	ingl	on D.C	20010	
	31. DATE FILE NOW, DOG YEAR 1994	32. REGISTRAR'S/SIGNA	135 - Randal	×.					0	/-		



FOR STATE REGISTRAR

1	1. DECEDENT'S NAME (First, MARY V	DORRELLE	2. DATE OF DEATH DAY YEAR December 2, 1994 6:45											
1	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. last birthday) IF UNDER t YEAR IF			IF UNDER	IF UNDER 24 HRS. 7. DATE OF BIR			Z, 1:	HPLACE (State or Foreign		
	577-01-492		1 □ M 2 🔯 F	89	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De	y, Vear)	1005	(Y)	
	9a. FACILITY NAME (If not in			0,		July 26, 1905 Virginia 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
DIRECTOR	Magnolia G	ardens	-	Home		Lanham Prince George								
i S	10a. STATE	10b. COUNT	1		10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
- 1	Maryland	Prince	e_George	s	La	nham						_		1 ¥ YES 2 □ NO
₹ I	10e. STREET AND NUMBER						10	H. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	6309 Martir	s Ter						2070	_			U.S	E .	
BY FU	1 Never Married 2 3 Widowed 4 Divo			YES 2	X NO		If yes, sp		ın, Maxica	NIC ORIGIN? (S in, Puerto Ricar y:		s or No	Spec	E — American Indian, ik, White, atc.
		EDENT'S EDU		16a.	DECEDENT'S	USUAL O	CCUPATI	ION	ng	16b. KIN	D OF BU	ISINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0		College (1-4 or 5		ille. Do NOT u	retired.)								
₹ I	12			El	ectro:	nics	Ins	-				onic	S	
- 1	Alvin C. Bo									ME (First, Middl A. San:				
8	19e. INFORMANT'S NAME (19b. MAILIN	G ADDRES	S (Street	_	_	Route Number, C			in Code)	
임	Jeanne E. U	Jline												20706
	20a METHOD OF DISPOSIT	ION	and the Canta	CE ANO OAT	09 Martins Terrace, Lanham, Maryland 20706 NO OATE OF DISPOSITION (Name OATE 20c. LOCATION City or Town, State							own, State		
	4 Donation 5 Other		OVEL ITOM State	Linc	remaiory or other place) incoln Cemetery 12/06/94 Brentwood, Maryland								Maryland	
	21, SIGNATURE OF FUNERA	L SERVICE LI	CENSEE			22.	NAME A	AND ADDRE	SS OF FA	CILITY				me, P.A.
	100	5.6	e e da											e, MD 20781
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Advancy Hysertens/in Cardis Revalled in Due to (or as a consequence of): Due to (or as a consequence of): Severy Hulma Due to (or as a consequence of): Severy Hulma Due to (or as a consequence of): Chrain Obstructive Lus Disease.													
MEDICAL	PART II. Other algolifica	ant condition	es contributing to	ot resulting	ulting in the underlying cause given in Part I.					PERFORMED? 1 YES 2 NO OF D			b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED T	TO MEDICAL						PLACE OF	OEATH (C	heck only one)				
Sic	1 YES 2 TOO		HOSPITAL:	☐ ER/Outpation	t 3 🗆 DOA	4 DAN		ma 5 🗆 R	lasidence	8 Other (S)	pecify)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 2 Accident	Pending Investigation	28a. DATE O	F INJURY Day, Year)	28b. TH	ME OF IJURY M	W	JURY AT ORK? YES 2	□ NO	28d, DEŞCRI	BE HOW	INJURY O	CCUREO	
ETED 8	A	Could not be determined	28e. PLACE (building	OF INJURY — A I, atc. (Specify)	t home, farm,	street, fac	ctory, offi	len			ON (Street own, State		er or Rural	Route Number,
COMPLE	Consol Only		ER: On the best of											(a) and manner as atated
TO BE C	29b. SIGNATURE AND TITE	E OF CERTIFIE	Any	jerry	EN			29c. LIC	ENSE NU	MBER (3-	29d. DA	TE SIGNE	0 (Month, Day, Year)
F	30. NAME AND ADDRESS O			308 Pe			, M	t. Ra	aini	er, Mai	ry1a	nd 20	0712	-2032
	DECO 2 199		32. REGISTA	iar's signatur	RE COL						7			
		- Z												DHMH-16 F

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



REG. NO

FOR

1 - STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 4 FLORENCE DOZIER 29 NOV. 1994 8:30 a M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER I YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS HOURS 1 □ M 2 🗓 F YRS. 578-42-3098 79 SEPT SOUTH CAROLINA Pages 1, 2, 3 should 9e, FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1122 KENNEBEC STREET #3 OXON HILL, MD PRINCE GEORGES 10e, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 1 X YES 2 NO PRINCE GEORGES OXON HILL permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? for use as the burial-transit 1122 KENNEBEC STREET #3 20745 USA hours after death. Page 6 may be retained by the hospital or attending physician. ti. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Merried B 3 🔀 Widowed 4 🗌 Divorced BLACK C 15. DECEOENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) and completely filled in by the funeral director, page 5 should be detached 6th 0 PRESSER LAUNDRY 17. FATHER'S NAME (First Middle | ast) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 JAMES CARTLEDGE BE ADLINE KEY notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DORA MONROE 1122 KENNEBEC STREET #3 OXON HILL, MD 20745 pe 20e. METHOD OF DISPOSITION

130 Burlal 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must LINCOLN CEMETERY BLADENSBURG, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY POPE FUNERAL HOME les 5538 MARLBORO PIKE. FORESTVILLE, MD 20747 medical 23. PART i. Enter the diseases, or compileatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** shock, or heert feilure. List only one ceuse on each ilne. Interval Between 6 IMMEDIATE CAUSE (Finei Onset and Death the cremation, disease or condition resulting in death) . CARCINOMA OF LUNGS event, DUE TO (OR AS A CONSEQUENCE OF): to burial, LADVANCED OBSTRUCTION LUNG DISEASE & EMPHYSEMIA traumatic CERTIFICATION Sequentially list conditions, OUE TO (DR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING the attending physician a Mental Hygiene prior to PROTEIN CALORIC MALNUTRITION CAUSE (Diseese or injury OUE TO (OR AS A CONSEQUENCE OF): thet initieted eventa resulting in deeth) LAST 10 d. ANEMIA any injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL signed by the 1 YES 2 NO Health DE DEATH? t TYES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗆 UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF OEATH (C eck only one) Item HOSPITAL: OTHER: 1 Deline Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b, TIME OF 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, with 1 Natural М 1 YES 2 NO BY DIRECTOR: After 1 hours after death death Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, factory, offica building, etc. (Specify) -3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide item 29a, CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end menner ee stated. THE FUNERAL D filed within 72 h PORTANT: If it 2 MEDICAL EXA nination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as atated, IMPORTANT: 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, H 풀 2.8 2 2 30. NAME AND ADDRESS OF CETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DAVID WILLIAMS 2041 Martin Luther King Ave Wash., D.C. 20020 32. JEGISTRAB'S SIGNATURE 31. DATE FILED (Month, Day, Year, DEC 0 2 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

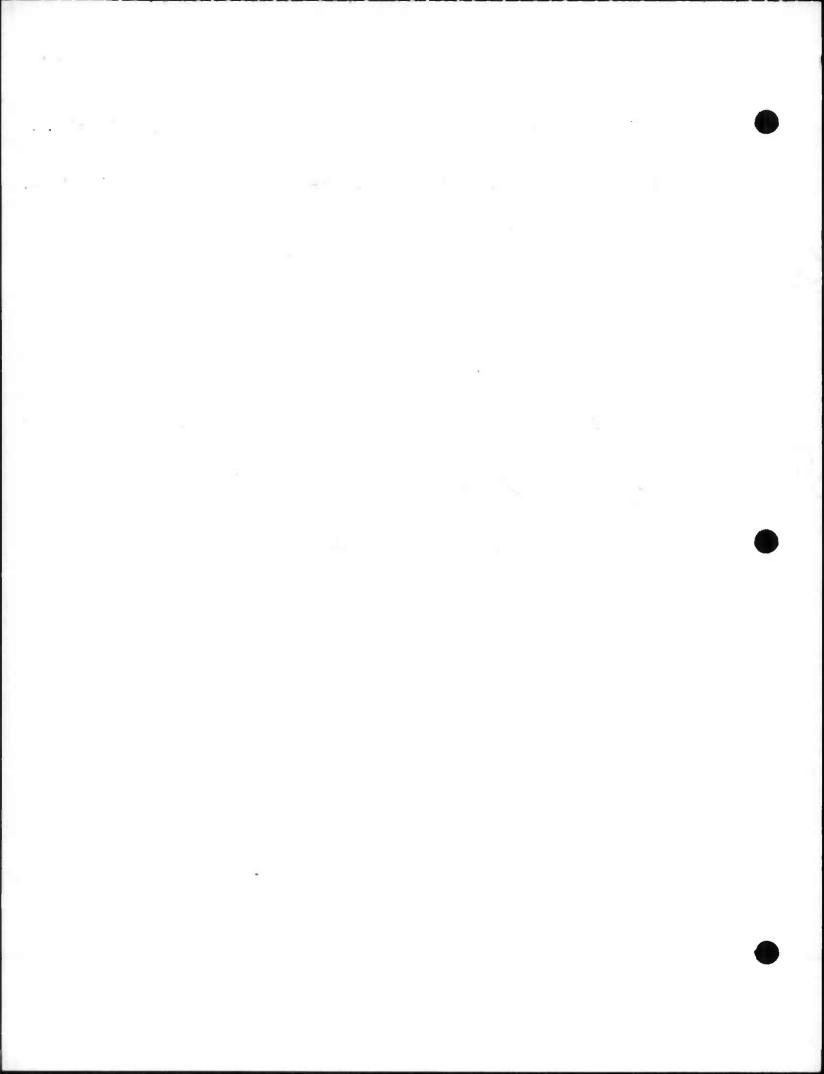
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / I		MENT OF I		MENTAL HYGIEN REG. NO.	E						
- 3	1. DECEDENT'S NAME (First, Middle, Last)	1111				2. DATE OF DEATH	V VE	3. TIME OF DEATH					
- 1	CORNELIUS JOSEPH				,	NOVEMBER "	25, 195	94 3:35p.m. m					
	577-05-9189	577-05-9189 1 M 2 F 78 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Count											
OR	90. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL 96. COUNTY OF DEATH LANHAM SEABROOK 97. TOWN OR LOCATION OF DEATH LANHAM SEABROOK												
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	T	10c. CITY.	TOWN OR LOCA	TION			10d, INSIDE CITY					
L DIRECTOR	Maryland Prince	e Georges	Lan	dover H	ills ————			1 XYES 2 NO					
FUNERAL	3909 73rd Avenue			10	20784		U.S.A	OF WHAT COUNTRY?					
B≺	1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 TYPES 2 NO IF YES, GIVE WAR OR DATES S. Army WWII		If yes, sp	ENDENT OF HISPAN ecify Cubsn, Mexicer 2 X NO Specify			RACE — Americen Indien, Black, White, stc. Specify: White					
COMPLETED	15. DECEDENT'S EOUCA' (Specify only highest grade co	mpleted) (Give College (1-4 or 5+)	EDENT'S U B kind of wo Do NOT use OOFER		ON st of working	J.S. Wa		RY					
17. FATHER'S NAME (First, Middle, Lest) James J. Desmond 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Dora Hayre													
TO B	190. INFORMANT'S NAME (Type/Print) Matilda R. Desmon	d 19b.	MAILING A	3rd Ave	enue, Lan	ndover Hill	n, State, Zip Cod S, MD	20784					
	20e. METHOD OF DISPOSITION 1 Deurle 2 Cremation 3 Remove 4 Donetion 5 Other (Specify)	al from State cemetery, crem	atory or other	DISPOSITION (No explace)		11/29/94	CATION — CITY O	or Town, State					
	21. SIGNATURE OF ENNERAL SERVICE LICEN	SEE Sul-		Rendon		om Funeral Ho ced, Lanham,)6					
	23. PART I. Enter the diseases, pr cpr shock, or heart fellure. Lis	mplications that caused the dear or only one cause on each line.	th. Op no	t antar tha mo	da of dying, auch	aa cardiac or reapi	ratory arrest,	Approximate Interval Between					
	iMMEDIATE CAUSE (Final disease or condition reaulting in death)	DUE TO (OR AS A CONSEQU	An	rest	•			Onaet and Daath					
NO	Sequentially list conditions, frame, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):												
CERTIFICATION	CAUSE (Disease or Injury C. End Diago Julinopian Disease												
CERTI	that initiated events reauting in death) LAST d. Recurrent factor into the last bleed in												
AL	PART II. Other algnificant conditions	contributing to death but not re-	aulting in	the underlyin	g causa given in i	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
PHYSICIAN: MEDIC						1 YES 2	Spio	COMPLETION OF CAUSE OF DEATH?					
Σ.	DID TORACCO LISE CONTRI	RUTE TO CALISE OF DEAT	H VES		UNCERTAIN			1 TES 2 NO					
NAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) FYAMINER?												
YSIC	1 YES 2 NO 1	OSPITAL: Impatient 2 ER/Outpatient 3		OTHER:	e 5 Reeldence	6 Other (Specify)							
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME INJUI	M 1 🗆	RK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURE	D					
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At hom- building, atc. (Specify)	e, ferm, str	eet, factory, offic	28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner se stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner se stated.												
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	p. pou	2		Dao3		P U	NED (Month, Day, Year)					
٢	30. NAME AND ADDRESS OF PERSON WHO CO Robert J. Cereige, M.	.D. 4410 75th Aven	ue, L	andover H	ills, MD	20784							
	NOV 2 8 1994	32. REGISTRAR'S SIGNATURE Julia Davidson-A	andell										



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CERTIFICATION

MEDICAL

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29b. Std

ATURE AND TITLE OF CERTIFIER

DY

RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

111

wie Davidson-Randall

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

NDING PHYS	R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Py	filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
G PHYSICIAN: 7	er this certificat	ith with the Sta	narked, or ite
무	DIRECTOR: Aft	nours after dea	tem 28 is m
THE HOSPITAL OR ATTE	HE FUNERAL	ed within 72 t	DRTANT: If I

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JAMES** FRANKLIN DOOMS NOV.25,1994 12:00 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 579-58-4917 DAYS 1 🔀 M 2 🗆 F Dec. 21,1945 **Alabama** 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9115 MARLBORO PIKE LOT 12 Upper Marlboro PRINCE GEORGES RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Upper Marlboro 1 YES 2 XNO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9115 Marlboro Pike Lot 12 20772 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married 1 YES 2 NO Specify 3 Widowed 4 Divorced Caucasian 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 10th N/A Auto Painter Stohlmen Auto Body 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Dooms Lucas Gorman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Floyd Avenue Waldorf, Md 20602 Lisa M. Dooms 20a. METHOD OF DISPOSITION

1 X Burlel 2 Cremetion 3 Re
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 30 complete, complete, complete, produced by Memorial Gardens 20c. LOCATION — City or Town, State 1994 Dunkirk, Maryland 21. SIGNATURE OF JUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735 23. PARTI. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ehock, or haart feijure. List pniv on ceuse on each lina intarvai Between IMMEDIATE CAUSE (Final **Onset and Deeth** disease or condition resulting in death) 0 DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF) if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evanta resulting in death) LAST PART II. Other aignificant conditions contributing to death but not recuiting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE YES 2 NO YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 XYES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 XRealdence 6 Other (Specify) 27. MANNER OF DEATH 20s. DATE OF INJURY 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES PLACE OF INJURY - At hope, farm, LOCATION uicide # Could not be 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and MEDICAL EXAMINER: On the is of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

OCME

Penn Street. Baltimore.

29d. DATE SIGNED (Month, Day, Year)

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1. DECEDENT'S NAME (First, Middle, Lest) WILLIAM F. I	DASCH	OL.	KIN IO	AIE OI	DEA		2. DATE OF DEATH MONTH NOV. 20.	w ₁₉₉₄	YEAR	3. TIME OF DEATH 5:30 a		
	4. SOCIAL SECURITY NUMBER 212 18 7092	5. SEX 1 ² M 2 F	6. AGE (In yrs. lest)		UNDER 1 YEAR ONTHS DAYS			7. DATE OF BIRTH (Month, Day, Year) Dec. 15,	a. BIRTHPLACE Country) Mary		ryland		
- 4	9a. FACILITY NAME (If not institution, give s	,	96	b. CITY, TOWN	on Locati			9c. COUN		ATH			
K F	5017 Durham Road	Last			OOLGHD LG								
DINE	Maryland How				Columb	111	H				10d. INSIDE CITY LIMITS? 1 YES 2 10		
FUNEHAL	5017 Durham Ros				01. ZIP COD 21	544	l fotal	10g. CITIZEN OF WI					
	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	IT EVER IN U.S. ARM FOR YES 2 NO.		If yes, s	CENDENT (pecify Cubics 2 NO	nn, Maxica	IIC ORIGIN? (Specify Yet n, Puerto Ricen, etc.)	or No—	14. RACE Black, Specify	- American Indian, White, etc.			
	15. DECEDENT'S EQU (Specify only highest grade Elementary/Secondary (0-12)		(Give	EDENT'S USI e kind of work Do NOT use re	UAL OCCUPAT done during retired.)	TION nost of worki	ing	16b, KIND OF BUS	SINESS/INDL		116 5 1		
	, , , , , , , , , , , , , , , , , , , ,	4		putor	Engir	neer		1 6 4		Ba	nk		
5	17. FATHER'S NAME (First, Middle, Lest) Elmer G Dasch				20			ME (First, Middle, Maiden h E Garret		M			
1	19a. INFORMANT'S NAME (Type/Print)		196.	MAJLINO AD	DRESS (Street	and Numbe	r or Rural I	Route Number, City or Tow	n State Zio	Code)			
2	Mrs Hilda G Dasc	Columbia	Md 21	044									
- 11	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)												
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		ke Funeral mbia Pike									
CERTIFICATION	Sequentisity list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO	O (OR AS A CONSEQUE)	UENCE OF):									
בסוסיו סבי	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WEI												
								1 □ YES 2	□ NO		AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? MOSPITAL: OTHER:												
	1 TYES 2 NO		☐ ER/Outpatient 3		THER:	me 5 DA	asidence	6 Other (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF (Month, E		28b. TIME O	Y V	JURY AT YORK?) NO	28d. DESCRIBE HOW I	NJURY OCC	URED			
	3 Suicide 6 Could not be determined	28a. PLACE C building,	OF INJURY — At hom, atc. (Specify)	ne, farm, stre	et, factory, of	ice		28f. LOCATION (Street a City or Town, State)	and Number o	or Rurel Ro	oute Number,		
	29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYS 2 MEDICAL EXAMINI										and manner as stated.		
	296. SIGNATURE AND TITLE OF CERTIFIE	Freeler	her	,			ENSE NUI		29d. DATE	SIGNED ((Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHE	Byech	SE OF DEATH (ITEM		int)								
I	31. DATE FILED (Month, Day Year)		AR'S SIGNATURE	arlall			-						

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D.E. WALLEY

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	_	REGISTRAR				CERTIF	ICATE O	F DEATH	1	REG. NO				
		1. DECEDENT'S NAME (First, M	liddle, Last)					·	2. D/	TE OF DEATN			3. TIME OF DEATN	
	1	THELMA	Δ	EMALINI	_		DENI	946			AY	YEAR	1000	
		4. SOCIAL SECURITY NUMBER		5. SEX	T	In yrs. last birthday			140	TE OF BIRTH	361	994	1850	
	1 8	The state of the s		1-4-			MONTHS DAYS			onth, Day, Year)		8. BIFTF	IPLACE (State or Foreity)	gn
29		221 18 0206		1 🗆 M 2 💢 F	66	YRS.			00	t. 27.	1928	Ma	ryland	
3 should		9a. FACILITY NAME (If not instit						OR LOCATION			9c. COUR	TY OF D	EATH	
	<u>۳</u>	PENINSULA 1	REGIC	DNAL MEDI	CAL	CENTER	SA	LISBURY	Y		W	COM	ICO	
permit. Pages 1, 2,	I K	RESIDENCE OF DECE	DENT											
S	Ĭ Ŭ	10s. STATE 16	Ob. COUNT	Υ		10c. CI	TY, TOWN OR LOC	ATION					10d. INSIDE CITY	
S.	DIRECTOR	Maryland	Wic	omico		D.							LIMITS?	_
ij.		10a, STREET AND NUMBER	WIC	Offico		P(wellville				_		1 TYES 2XXX	
8	₹							10f. ZIP CODE			10g. CITI	EN OF V	VHAT COUNTRY?	
n. ansi	單	P.O. Box 21		_				21852			U.	SA		
BALLIMORE, MARYLAND 21215-0020 et death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit val.	FUNERAL	11. MARITAL STATUS		12, WAS DECEDEN	T EVER IN	U.S. ARMED	S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Veg or No. 14. BAC							
		1 Never Married 2 Ma		FORCES? 1	MAR OR DA	TES NO		specify Cuban, N ES 2 XNO :	flaxican, Puar Specify:	to Rican, etc.)			k, White, atc.	
	BY	3XNVidowed 4 □ Divorce	d				1 '' ''	Xiio	opouny.			Spec	" White	
r attend	8	15, DECED	ENT'S EDU	CATION		16a. DECEDENT	S USUAL OCCUPA	TION		16b. KIND OF BU	CINECC/IND	ICTOV		
or at	151	(Specify only hi	ighest grade	completed)		(Give kind of	work done during i	most of working	P	IOD. KIND OF BO	SINESS/IND	vaini		
the hospital or detached for once.		Elementary/Secondary (0-12	9)	College (1-4 or 5	+)									
	COMPLET	. 11				Countr	y Store	<u> Manag</u>	er	Service	Stat	ion		
		17. FATHER'S NAME (First, Midd						16. MOTHER	'S NAME (Fin	st, Middle, Maiden	Surname)			
Z & & Z	6 Lut	John F. Bal	ker					Jewe	l Wes	sells				
MAR retained to 5 should	00	19a. INFORMANT'S NAME (Type	VPrint)			19b. MAJUN	G ADDRESS (Stree				n State Zin	Codel		
M reta	임	Linda Faye E		ngham									1000	
P Dage	2			пупаш	_		Powell		a. P				1850	
nours after death. Page 6 may be d in by the funeral director, page or removal.	5	20a. METNOD OF DISPOSITION N Burlel 2 □ Cremation		oval from Stata		PLACE AND DATE etery, crematory or	OF DISPOSITION	Name of	0	ATE 20c. LO	CATION —	City or To	wn, State	
Pectro 6		Buriel 2 Cremation 4 Donation 5 Other (Sc			- Po	wellville	Cemet	erv	11//2	9/94 F	lawo	witt	MD	
ALTIM death. Page funeral dire		21. SIGNATUME OF FUNDANLS	ERVICE LIC	CENSEE				AND ADDRESS	OF FACILITY					
Lines ath		V MA.	, 1				۱۵.	_					ams St.	
BA Ber de the frithe friends		11 YUR	7.40	ulaje			Burl	page Fi	unera	I Home	Berli	n, l	MD 21	81
B after removal		23. PART I. Enter the dise	asas, or	complications the	t caused	the death. Do	not enter tha n	node of dylng,	, such as c	ardiec or resp	ratory arr	est,	Approximate	_
d in		shock, or heer	rt failure.	List only one ceu	use on ea	ich line.							Interval Bety	ween
		iMMEDIATE CAUSE (Final disease or condition				-			0				Onset and D	/eatr
ompletely fille		resulting in death)	•	1. EN	0	277	se (OP	0				VENTE	2
mplet				DUE TO	(OR AS A	CONSEQUENCE)	(F):						X	
		is an analysis and an analysis and	-		Cu	malle	cuse						7	
OX 68 e be execute sician and c nior to bunit	CERTIFICATION	Sequentielly list condition If any, leading to immedia		DUE TO	(OR AS A	CONSEQUENCE (off);							
iciai p		cause. Enter UNDERLYING												
m # } " =		CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF):												
	SI Ē I	resulting in death) LAST												
Geath of the attend ental Hy				d										
		PART II. Other significent	condition	s contribution to	death hi	et not requision	in the renderedal	an anima atiu	a la Cart I	1		1		
RD:	EDICAL			4		. 0			m m Part I.	24a. WAS AN PERFOR		240	WERE AUTOPSY FIND AVAILABLE PRIOR TO	
COR ires that signed by fealth an		multi Focal		TICOTE	- 1"	Telly Co	HUIA			1 TYES 2	NO		COMPLETION OF CAU DF DEATN?	ISE
										1				
REGuil w requir	Σ	DID TOBACCO USE	CONT	DIDLITE TO CA	LISE OF	E DEATH V	EC TO NO I	LINICED	TAINI 🗆				1 YES 2 NO	
2 eg 8 e	1 6 1			KIBUIE IO CA					TAIN 🔲					
V: The cate h State (히히	25. WAS CASE REFERRED TO N EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE OF DE	OTHER:	o)						
SICIAN: The certificate by the State of the State of the State of the State of the state of the	् ।	1 YES 2 NO		1. Inpetient 2	ER/Outpa	etlent 3 🗆 DOA		ome 5 🗆 Reside	enca 6 🗆 O	ther (Specify)				
VISION OF VITA ATENDING PHYSICIAN: The ECTOR: After this certificate his s after death with the State to 28 is marked or item		27. MANNER OF DEATH		28a. DATE OF		26b. Til		NJURY AT	28d. 1	DESCRIBE NOW I	NJURY OCC	URED		
NG PHYS ther this clearth with		1 Natural 5 Per		(Month, E	Jay, Year)	l IN		YORK? YES 2 N	0					
OR ATTENDING POINTENDING POINTENDING POINTENDING PARTY PARTY PROUTS after death		- Coloria	estigation	20. 01 405 0	F (4) 11 1504	111								
END END END			uld not be armined	building,	etc, (Speci	— At nome, term,	atree1, factory, off	ree1, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
OIVIST OR ATTEN DIRECTOR: Hours after tem 28 M	41 ⊨ 1	4 _ Nomicide Gen	ar iinii yesa											
OR DIR		29a, CERTIFIER 1 CERTIFY	ING PHYSI	ICIAN: To the heet of	my knowle	adae deeth occur	and at the time de	to and alone as	4 4 4 . 4			,		
Z ZZ =	: 🕏			CIAN: To the best of										
HOSPITAL FUNERAL WITHIN 72 I	COMPLI	A L MEDICA	- CARRINE	on the pasts of a	AGING THE COLUMN	end/of investigati	ייי, ורו my opinion,	weath occured a	at the time, d	eta and placa, an	d due to the	cause(s) and manner as atate	ad.
TO THE HOSPI TO THE FUNER be filed within	E	29b. SIGNATURE AND TITLE OF	CERTIFIE	R				29c. LICENSI	E NUMBER		29d. DATE	SIGNED	(Month, Dpy, Year)	
五 法 是 是 是 是 是 是 是 是 是 是 是 是 是 是 是 是 是 是														
0 0 0 5	9	7,	1/0		un			()-	3981	3	D 2	1/>	2/94	
P P 2 2	TO B	30. NAME AND ADDRESS OF PI	- 1/1		U SE OF DEA	TH (ITEM 27) (Em	o Print)	DE	3981	3	> 0	1/2	7/94	
223	TO B	30. NAME AND ADDRESS OF PI	- 1/1		SE OF DEA	TH (ITEM 27) (Typ	e, Print)	DE	3981	5	> 0	1/2	7/94	_

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
HYSICIAN; The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal.	ked, or item 23 shows any injury, or other traumatic event,	
TO THE HOSPITAL OR ATTENDING PH	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	IMPORTANT: If Item 28 is marked	

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

_	TEGIOTIBAL					OATE	- 01	טבה.	111	REG. N	Ų.		
	1. DECEDENT'S NAME (First, CHARLES	, Middle, Last) EDWAR	D DAV	TS						2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH 2:20 P M
3	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. las			t birthday) IF UNDER t YEAR IF UNDER 24 HRS.									
	234-40-340	4	™ M 2 □ F	65	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 04 11	29	Country	
E	9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL					9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND Sc. COUNTY OF DEATH ALLEGANY							
5	RESIDENCE OF DEC		JULIAL				OFIDE	INLAN	D		AL	LEGAL	I
DIRECTOR	10a. STATE WV	Minera	ıl			Fort Ashby					10d. INSIDE CITY LIMITS?		
FUNERAL	10e. STREET AND NUMBER	22						ZIP CODI			10g. CIT		HAT COUNTRY?
NE.	H.C. 86 BOX		WAS DECEDEN	T EVER IN U.S. ARI	4ED	1 40 1		6719					
E	1 Never Married 2 🔀	Married	FORCES?	YES 2 N	0	1 1	f yes, sp	ecity Cuba	n, Mexice	IC ORIGIN? (Specify) n, Puerto Rican, etc.)	es or No-	Black,	— American Indian, White, atc.
ВУ	3 Widowed 4 Divo	rced	1950-1952				☐ YES	213 NO	Specify	:	white		
目	15. DEC (Specify only	EDENT'S EDUCAT y highest grade con	ION npleted)	(Gh	EDENT'S	vork done o	CUPATIO	ON st of workin	ig	16b. KIND OF B	USINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0	1-12)	College (1-4 or 5 +	-)	Qua.	,	Con	trol	Tec	h Text	le		
	17. FATHER'S NAME (First, M. Elmer Da									ME (First, Middle, Maide (Mahle)	n Surname)		
) BE	19a. INFORMANT'S NAME (7)			19b	. MAILING	AODRESS	(Street a			loute Number, City or To	wn, State, Zi	ip Code)	
2	Lorraine Da									shby, WV	2671		
	20a. METHOO OF DISPOSITI 1 Burlai 2 Crematio 4 Donation 5 Other	n 3 🗆 Remove	I from State	20b. PLACE A cemetery, creat FOIT						11/28 FC		shby,	
	21. SIGNATURE OF FUNERAL	L SERVICE LICEN	SEE		11				SS OF FAC	eral Home			
	Gan	017	20010	and	11	C	mbe	rlan	d, M	D 21502			
	23. PART Enter the di	seesea, or con	plicátions that	t ceused the de- se on each line.	un. Do n	ot enter	the mo	de of dyl	ng, auch	as cerdiec or ree	piratory ar	теаt,	Approximete interval Between
ŀ	IMMEDIATE CAUSE (Fin		Ω										Onset and Death
	resulting in death)	disease or condition resulting in death) a. PNEUMONIQ DUE TO (OR AS A CONSCOUENCE OF):											
z		6.											į į
ATIO	Sequentially list conditi if any, leading to immediate. Enter UNDERLYI	diate	DUE TO	(OR AS A CONSEO	UENCE OF):							
SE I	CAUSE (Disease or Inju		DUE TO	(OR AS A CONSEO	UENCE OF):							
CERTIFICATION	resulting in death) LAS	T d											
F C	PART II. Other significe	nt conditions c	ontributing to	death but not re	sulting i	n the un	derlylng	g ceuse g	given in i		N AUTOPSY		WERE AUTOPSY FINDINGS
EDICAL	BRA	IN T	umoi	<u> </u>						1 _ YES	2 XNO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ										_		- 1	t ☐ YES 2 NO
AN I	DID TOBACCO U		UTE TO CA	USE OF DEAT				UNC	ERTAIN	1 🗆 📗			
PHYSICIAN:	EXAMINER?	Н	OSPITAL:	ER/Outpatient 3		OTHER	l:	e 5 □ Re	aldence	8 Dther (Specify)			
둦	27. MANNER OF OEATH		28a. DATE OF (Month, De	INJURY	28b. TIME	OF	28c. INJ		arounca	28d. OESCRIBE HOW	INJURY OC	CURED	
BY		Pending Investigation		0.50		М	1 🗆 1	'ES 2 [NO				
		Could not be determined	28a. PLACE Of building,	F INJURY — At hon atc. (Specify)	ne, farm, s	treet, facto	ory, office			26f. LOCATION (Stree City or Town, State		r or Aural Ro	ute Number,
P.E.	29a. CERTIFIER (Check only	IFYING PHYSICIA	N: To the best of	my knowledge, daa	th occurre	d at the ti	me, data	and place,	and dua	to the cause(a) and m	anner as gla	rted.	
COMPLETED	anal												and manner as stated,
BE	296. SIGNATURE AND TITLE	OF CENTRAL	-	00	1			29c. LICE	NSE NUM	BER)	29d. DAT	E SIGNED	Month, Pay, Year)
2	30. NAME AND AGORESS OF	PERSON WHO C	OMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)		Do	15	* TT	/	112	8/44
	DR. PAUL LI					RIVE	, CU	MBER	LAND	, MD 2150	2		
	31. DATE FILED (Month, Day,		32. REGISTRA	EUCLEAN A	dall								
	110 4	- 100	_/										DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 -	FOR STATE REGISTR	AF
1. D	ECEDENT'S	N/

_	REGISTRAN		O.	-13111	ICAIL	OF	DEATH		HEG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)	Eu	igene W	7111	iam	D	uKES	2. DATE O	DA	44/0	YEAR 1994	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1	VEAR	IF UNDER 24 HRS.	7. DATE C		0		PLACE (State or Foreign
N	218-20-4057 1⊠M2□F			YRS.	MONTHS	DAYS	HOURS MIN.	(Month,	Day, Year)	2.5	Country	
	9a. FACILITY NAME (If not institution, give street and number)						96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					
DIRECTOR	PENINSULA REGIO	NAL MEDIC	CAL CENT	ER	S	ALI	SBURY			(2)	WICOM	ICO ·
5	RESIDENCE OF DECEDENT											
	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN OF							10d. INSIDE CITY LIMITS?
		nerset				Pa	rsonbu	rg				TYES 2 NO
₹١	10e. STREET AND NUMBER					101	. ZIP CODE					HAT COUNTRY?
<u> </u>	6947 Fo	orest Gr	ove Ro	ad			2184	49		Un	ited	States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED			ENDENT OF HISPAI			or No-	14. RACE	- American Indian, White, atc.
BY	1 Never Merried 2 Merried FQRCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES						2 NO Specif		can, arc.)			White
	15. DECEDENT'S EDI (Specify only highest grad		18a. DE	CEDENT'S	USUAL OC	CUPATIO	ON set of working	16b.	KIND OF BUS	SINESS/IN	DUSTRY	
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5 +	illo.	Do NOT u	se retired.)	uning mo	st of working		_	25		
ᆲᅵ	Sixth		M	echa	anic				Heavy	Eq	uipm	ent
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)						18. MOTNER'S NA	ME (First, M	iddle, Maiden	Surname)		
		Henry	Dukes				I	Pear	L			
8	19a, INFORMANT'S NAME (Type/Print)		190	b. MAILING	ADDRESS	(Street s	and Number or Rural	Route Numb	er City or Tow	n State Zi	in Code)	
임	Robert B. Gre	acory					Eden, N					
	20a, METHOD OF DISPOSITION	GOLY	20b. PLACE/				PAT 181 PAGE 1	DATE		CATION	City or Tov	- State
	1X Burial 2 ☐ Cremation 3 ☐ Ren	novel from State	cemetery, cre	matory or o	ther place)				-			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	- ISpri	ngh:		Mem	Ory Gal	cden	Sal	ISD	ury,	MD
- 0		2 2							ng_Ec	elcow.	Fun	eral Home
	Michael 7.	askow			P	OB	ox 43.	Fede	erals	shur	a. M	D 21632
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
CER	resulting in death) LAST	d										
A	PART II. Other algnificent condition	_		_	In the und	derlyin	g ceuse given in	Part I.	24a. WAS AN PERFOR		246.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
EDICAL	ATRIA	FIBR	1445	.01					1 TYES 2			COMPLETION OF CAUSE OF DEATH?
ME	ASPIRA	TION 1	PNEVA	0~	.0			27				1 YES 2 NO
PHYSICIAN:												
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		LACE OF DEATH (Ch	eck only one)			
Z	1 TES 2 NO	1 Cinpatient 2			4 - Nurs		e 5 - Residence	8 - Other	(Specify)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D		28b. TIR	IE OF JURY M	WC	URY AT DRK? YES 2 NQ	28d. DES	CRIBE HOW I	NJURY O	CCURED	
	3 Suicide a Could not be 4 Nomicide determined	28s. PLACE O building,	F INJURY — At ho etc. (Specify)	ome, farm,	street, facto	ory, offic	•	28f. LOCA City o	TION (Street : r Town, State)	and Numbe	or or Rural R	oute Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYS											and manner as stated.
96	29b. SIGNATURE AND TITLE OF CERTIFIE	ER .					29c. LICENSE NU		53		TE SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type		Sal	isbury	m-	121	801		
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	AR'S SIGNATURE	100	T	TIL	135000	1710	1 4 1	20		
	NOV 16 '94	0	vidson-Ray	ndapp.			,					

0.7 2.07				
				1.1.10
				1.1.16
				1.1.16
				1.4.80
				1-1-15
				1.4.80
				1.4.180
				1.4.180
				1.4.180
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				1.4.16
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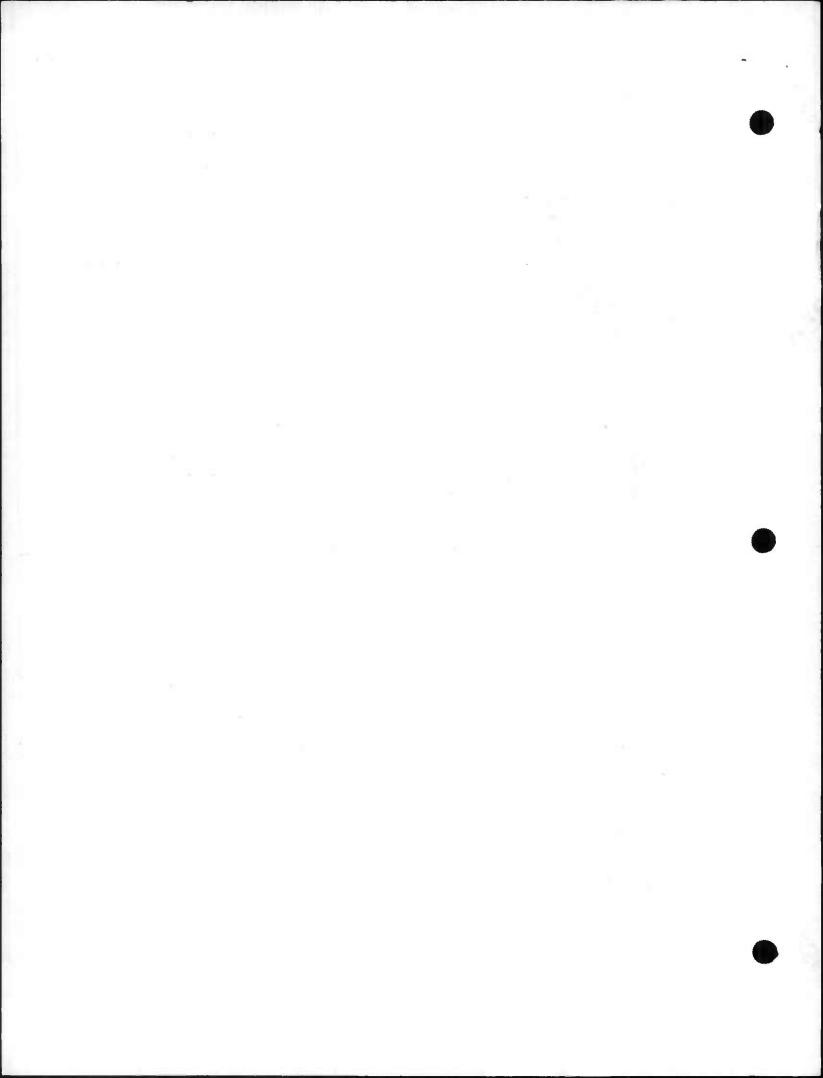
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME DF DEATH	
	MARTAN VTOI	LA DAWSON				NOV.25,	1994 YEAR	1:20AM M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		THPLACE (State or Foreign	
	201-24-1069 90. FACILITY NAME (If not institution, give	1 FEMALE	63 YRS.	DAYS	Nov 6, 19	931 PENNSYLVANIA Sc. COUNTY OF DEATH			
TOR	8003 ROCKY RIDGE	OO3 ROCKY RIDGE RD. THURMONT						ICK	
DIRECTOR	MD FRI	EDERICK	10c. CITY, TO THURM	OWN OR LOCAT	ON			10d. INSIDE CITY LINE 15? 1 YES 2 NO	
FUNERAL	106. STREET AND NUMBER 8003 ROCKY RIDGE	RD.		101.	ZIP CODE 2178	8		S.A.	
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed MA Toblocopt	12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO		cify Cuben, Mexica	HC ORIGIN? (Specify Yee n, Puerto Rican, atc.)	Bla	- 14. RACE — American Indian, Black, White, etc.	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use re	done during mos	N It of working	16b. KIND OF BUS	SINESS/INDUSTRY		
3	6	Conege (1-4 or 5+)	ASSEMBLY	LINE W	ORKER	MANU	FACTURI	NG	
S S	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden :	Surname)		
BEO	WALTER LOWERY				SARA	H DEVORE			
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILIND AD	DRESS (Street as	nd Number or Rural I	Route Number, City or Town	n, State, Zip Code)		
٦	CHESTER W. DAWSON		8003 ROC	CKY RID	GE RD.TH	URMONT	M.	D 21788	
	20a. METHDD OF DISPOSITION BUIL 1 Burlet 2 Cremation 3 Ref 4 Donation 5 Other (Specify)	RIAL 20t con	RESTHAVEN			NS20 NR	ATION — City or FREDE		
	21. SIGNATURE OF PUNERAL SERVICE L	ICENSEE	4	22. NAME AN	D ADDRESS OF FA	CILITY D. D.			
	* Thanise (V. Harty	ler	-		ORO, MD			
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finst disease or condition resulting in death)	a	each line.			Buent G		Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (DR AS A CONSEDUENCE OF): c. DUE TO (OR AS A CONSEDUENCE OF): d								
AL	PART II. Other significant condition	na contributing to death b	out not resulting in the	he underlying	cause given in	Part 1. 24a. WAS AN PERFOR 1 TYES 2	MED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
Σ	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH Y	ES I NO	<u> </u>		1 TYES 2 ND	
AN	25. WAS CASE REFERRED TO MEDICAL	33			ACE DF DEATH (Ch	الم			
S	EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:	Allelan	8 Other (Specify)			
PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE DF INJURY (Month, Day, Year)	28b. TIME OF	F 28c. INJI	JRY AT	25d. DESCRIBE HOW IP	NJURY OCCURED		
ED BY	2 Accident Investigation 3 Suicide 5 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY building, etc. (Spe	/ — At home, tarm, atree			28f. LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,	
COMPLETED		SICIAN: To the beat of my know IER: On the beele of examination						o(e) end manner ae stated,	
B	29b. SIGNATURE AND TITLE OF CERTIFIE	er Wand			29c. LICENSE NUN			ED (Month, Day, Year)	
유	#3 FR	HOMAS JOHNSON [EDERICK MD 2170)R)2	nt)					
	31. DATE FILED (Month, Day, 1630) 1-6 NUV 3 0 1994	94-17 DEGISTRAR'S GIGN	ATURE	-					



Pages 1, 2, 3 should

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fours after death. Page 6 may be	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	POE	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be

31. DATE FILED (Month, Day, Year)

MRT Montgomer STATE OF MARYLAND I DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1994 22, 1:20 Esther Evans Nov. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 579-01-9492 Feb. 6,1912 Wash., D.C. 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital 01nev Montgomery 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Montgomery Silver Spring 1 TY YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 3330 North Leisure World Blvd. 20906 USA 11. MARITAL STATUS 12, WAS DECEDENT EVER IN U.S. ARMED WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— It yes, specify Cuben, Mexicen, Puerlo Ricen, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Merried 2 Merried BY 3 Widowed 4 Olvorced 1 TES 2 NO Specify: Specify: White ETED 15. DECEOENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Secretary N.A.S.A. once 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) August A. Weber Bertie B. Lamb 7 notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 James Raymond Evans 407 Watts Branch Pkwy., Rockville, MD 20854 20a-METHOD OF DISPOSITION e 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must Cremetion 3 - Removal from State Gate of Heaven Cem. 4 Donation 5 Other (Specify) 11/26 Silver Spring, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory street, Approximate ahock, or haart failura. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onsat and Daeth the disease or condition resulting in desth) . Septacemia 48 hrs. event, OUE TO (OR AS A CONSEQUENCE OF): traumatic ⊾ Pneumonia 48 hrs. CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO Arteriosclerotic cardiovascular disease апу COMPLETION OF CAUSE 1 YES 2X NO Shows 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO 1 Nopetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO is marked, 1 📉 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined COMPLETED 4 Homicide item 29e. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my killion edges, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. FUNERAL 1 within 72 h 2 MEDICAL EXAMINER: On the beels of examination and/o TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yber) BE MD 8387 Nov. 22, 1994 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Benjamin Avrunin, M.D., 18111 Prince Philip Dr., Olney, MD

32. BEGISTRAR'S SIGNATURE Julia Davidson-Randalle

e x x x x a ±511.

	1 - STATE REGISTRAR	CI	ERTIF	ICATE O			WENTAL THE				
	1. DECEDENT'S NAME (First, Middle Last)	ArdS William		Edwards	, Jr.		2. DATE OF DEA MONTH	29"	q ² 2		209 PM
	182-16-6136	5. SEX 6. AGE (In yrs. las	YRS.	IF UNDER 1 YEAR	\$ HOURS	MIN.	7. DATE OF BIRT		Co	ountry)	E (State or Foreign Lvania
DIRECTOR	9a. FACILITY NAME (If not institution, give stree Suburban Hospital RESIDENCE OF DECEDENT			Bethe	n or locations of a	ON OF DE	ATN /		ontgo		
EC	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LO	CATION		_			10d	INSIDE CITY
B	Maryland Montgo	omery	Ве	thesda							LIMITS?
FUNERAL	100. STREET AND NUMBER 4503 Conifer Lane				10f. ZIP CODE			10	g. CITIZEN (OF WNAT	
M					208					SA	
B≺	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 ☑ YES 2 ☐ P IF YES, GIVE WAR OR DATES 1941—1945		If yes		n, Maxica	IIC ORIGIN? (Speci n, Puerto Rican, at			RACE — Ar Black, White Specify: Wh	
	15. DECEDENT'S EDUCA (Specify only highest grade co		CEDENT'S	USUAL OCCUP	ATION		16b. KIND O	F BUSINE	SS/INDUSTR	?Y	
E		College (1-4 or 5+)	Do NOT u	se retired.)	most or workin	v					
MP	12	2	Buil	lder			Со	nstr	uctio	n	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTH	IER'S NA	ME (First, Middle, M	elden Sum	ame)		
BE (William Morris Edv	ards, Sr.			Εv	a So	outhall				
6	19a. INFORMANT'S NAME (Type/Print)						Route Number, City of			,	
-	Velma C. Edwards		503 (Conifer	Lane,	Bet	chesda,	Mary	land	208	14
	20a. METHOD OF DISPOSITION 1	al from State 20b. PLACE /	AND DATE	OF DISPOSITION	(Neme of		DATE 20				
	4 ☐ Donation 6 ☐ Other (Specify)		TTOMS	Cemet							nnsylvania
	> Muly DK	wald.		1180	0 New	Hamp	oshire A Maryla	venu	aldi e 20904		ral Home
	23. PART I. Enter the diseases, or con	mplications that caused the da st only one cause on each line	ath. Do i	not anter tha	moda of dyi	ng, sucl	n aa cardiac or	raspirato	ry arrest,		Approximata
	iMMEDIATE CAUSE (Final			nary	arr	u+					Interval Batween Onset and Death
NO	Sequentially list conditions,	DUE TO (OR AS A CONSEC DUE TO (OR AS A CONSEC DUE TO (OR AS A CONSEC	es t	incl	B1.	eed	ing				
ICATI	cause. Enter UNDERLYING CAUSE (Disease or Injury	Coasulo pa					3				
CERTIFICATION	that initiated events reaulting in death) LAST	End Stay			dyp	pla	HKC S	ndr	une		
	PART il. Othar aignificant conditions	contributing to death but not r	asulting	In the underly	Ing cause g	ivan in		S AN AUT			AUTOPSY FINDINGS
PHYSICIAN: MEDICAL								RFORMED ES 2 🔯 I		COMP	ABLE PRIOR TO PLETION DF CAUSE
Ä								-			YES 2 NO
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEA	TH YE	S 🗆 NO	☐ UNC	ERTAIN	N 🖾				
Y	25. WAS CASE REFERRED TO MEDICAL	26. PLAC		TN (Check only o							
Sign	the state of the s	HOSPITAL: Inpatient 2 ER/Outpatient 3	□ DOA	OTHER: 4 Nursing F	ome 5 🗆 Re	aldence	6 Other (Specify)			
ا څ	27. MANNER OF DEATH	26s. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 26c.	INJURY AT WORK?		26d. DESCRIBE N	OW INJUR	TY OCCURE	D	
BY	1 Natural 5 Pending 2 Accident Investigation	(month, buy, total)			YES 2	NO					
<u>a</u>	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY — At ho building, atc. (Specify)	me, 1erm, :	streat, factory, o	ffica		261. LOCATION (S City or Town,		lumber or Ru	iral Route N	lumber,
COMPLET	one)	AN: To the best of my knowledge, de									introcension
႘		On the beels of examination and/or (nvestigatio	m, in my opinioi	_			a, and du	J 10 the cau	se(s) and r	nanner as stated.
H H	29b. SIGNAPURE AND TITLE OF CERTIFIER	2/1000	1	17	29c. LICE	NSE NUM	BER	290	DATE SIG		n. (Day, Year)
ဥ	30. NAME AND ADDRESS OF PERSON WHO	sury Ph	JYY	1)	$\perp D$	34	140		11/	29	144
	J. Garrett Reilley	, PHD, MD 11510) 01d		etown	Rd.	Rockvil	le, l	4d 2	0852	
	DEC 0 2 1994	22. RECISTAN'S ALCOHOLINE	مباقا								

TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

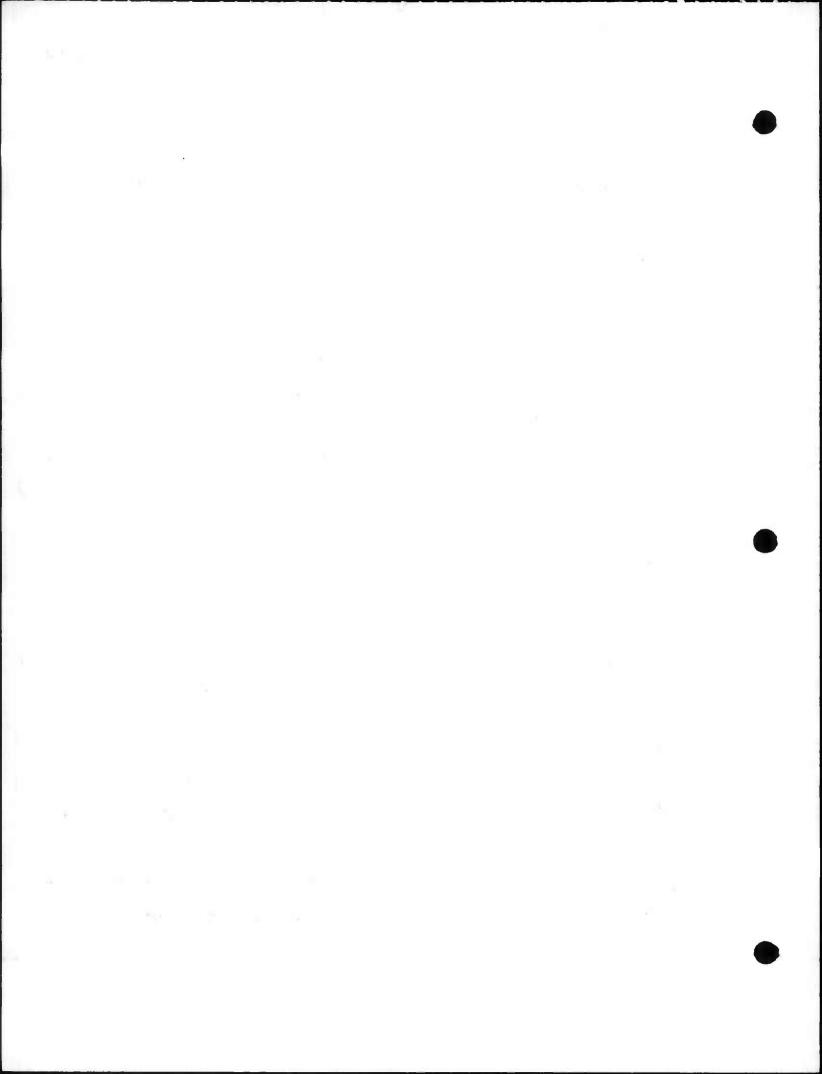
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

lours after death. Page 6 may be retained by the hospital or attending physician.	J in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 s or removal	medical examiner must be notified at once.
HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	UTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s filled within 72 hours after death with the State Deot. of Health and Mental Moriene prior to burial, cremation, or removal	TANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	ATE OF MARYLAND / DEPART	MENT OF HEALTH AND	MENTAL HYGI					
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEAT	н	3. TIME OF DEATH			
	TRACEY J. EI	LIOTT		NOV.		7:00 P M			
	4. SOCIAL SECURITY NUMBER 5. SE	(m) (m) (m) (m) (m) (m) (m) (m)	IF UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF BIRTH	l a	BIRTHPLACE (State or Foreign Country)			
		M 2 X F 25 YRS.	MONTHS DAYS HOURS MIN.	JULY 1,		ORTH CAROLINA			
œ	9a. FACILITY NAME (If not institution, give street and 1415 DUNWOODY DR.)		9b. CITY, TOWN OR LOCATION OF OXON HILL	DEATH		Y OF DEATH ICE GEORGES			
DIRECTOR	RESIDENCE OF DECEDENT	. • • • • • • • • • • • • • • • • • • •	OXON HIBE		FILL	CE GEORGES			
R	10a. STATE 10b. COUNTY		TOWN OR LOCATION			10d. INSIDE CITY LIMITS?			
		GEORGE'S	OXON HILL			1XXYES 2 NO			
FUNERAL	100. STREET AND NUMBER 5119 DEALE DRIVE	λDT #202	10f. ZIP CODE	4 =		N OF WHAT COUNTRY?			
N.		AFT. #ZUZ	2074			U.S.A.			
	1- Never Merried 2 Married FG	DRCES? 1 YES 2 NO YES, GIVE WAR OR DATES	If yes, specify Cuban, Mex 1 ☐ YES 2 NO Spe	ican, Puerto Rican, atc.)	Black, White, etc.			
D 8Y	3 Widowed 4 Divorced					BLACK			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of w	JSUAL OCCUPATION ork done during most of working matined)	16b. KIND OF	BUSINESS/INDUS	STRY			
PL	Elementary/Secondary (0-12) Colle 12th	ige (1-4 or 5+)	TRY CLERK	G	OVERNM	ENT			
Ö	17. FATHER'S NAME (First, Middle, Last)			NAME (First, Middle, Me.		DIV 1			
BE (RONNIE ELLIOTT			CENT K.					
TO E	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street and Number or Run	al Route Number, City or	Town, State, Zip Co	ode)			
	MILLICENT K. JONI								
	1 X Burial 2 ☐ Cremetion 3 ☐ Removal fro	20b. PLACE AND DATE Of complexy, Grematory or oth	ner place)	1	LOCATION — CR	y or Town, State , MARYLAND			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE								
	Samuery C. B.		J.B. JENKINS 7474 LANDOVER						
	23. PART i. Enter the disease, or compile shock, or heart failure. List or IMMEDIATE CAUSE (Final disease or condition	nly one cause on each line.		uch an cardiac or re	papiratory arres	Approximate interval Between Onset and Death			
	resulting in death)	OUE TO FOR AS A CONSEQUENCE OF							
z									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
2	CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENCE OF							
	that initiated avanta resulting in death) LAST	DOE TO (ON AS A CONSECUENCE OF)	is a second seco		201	i l			
	d								
SAL	PART il. Other eignificant conditione cont	ributing to death but not resulting in	tha underlying cause given	PER	AN AUTOPSY FORMEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
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PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF OEATH							
Sic		PITAL: npstlant 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home 5 Realdenc	a XXOther (Specify)	TNSTD	E CAR			
F	27. MANNER OF DEATH 2 1 Netural 5 Pending	Se. DATE OF INJURY (Month, Clay, Year) 26b. TIME INJU	OF 28c. INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCU	REO			
B⊀	2 Accident Investigation	11 20 94 1602 8a. PLACE OF INJURY — At home, farm, at	M 1 YES 2 NO			teral Times			
	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Specify)		City or Town, S	tate)	Rural Route Number,			
9	29a. CERTIFIER 1 CERTIFYING PHYSICIAN, T	the best of my knowledge, death occurred				E, OXON HILL MD			
COMPLETED		he basis of my knowledga, death occurred							
	290. SIGNATURE AND TUBE OF PERTIFIER	70	29c. LICENSE N			SIGNED (Month, Day, Year)			
BE O	John & Sille	>+++ N	O.C.M			V. 21,1994			
임	30. NAME AND ADDRESS OF PERSON WHO COMP	. V 1 -	Print)						
	MARIO F. GOLLE, J		Street, Ba	ltimore,	Maryl	and 21201			
	31. DATE FILEO (MAINT), P.O. 1902 NOV 2 8 1994	Tulia Day doon-Randall							



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OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24
5	DR
	HOSPITAL

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Maggie Elliott 2055 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Morth, Day, Year) 7-09-07 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 216-12-1011 8.7 1 - M 2 TF Delaware use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Peninsula Regional Salisbury Wicomico RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Wicomico Salisbury 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 105 Times Square 21801 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 2 NO 1 Never Married 2 Married 1 YES 2 XNO Specify: BY 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Elijah Baker Ida Mae Wells 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Addola Cox 31067 Old Fruitland Rd. Salisbury, MD pe 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Sunset Memorial Park 11/27/94 Berlin, MD 21811 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY 108 Williams St. Burbage Funeral Home Sufal Berlin, MD filled in by the fion, or removal. 21811 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final attending physician and completely fille ontal Hygiene prior to bunal, cremation, traumatic event, the disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease vears DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 5 this certificate has been signed by the atter Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE any Chronic Obstructive Pulmonary Disease 1 TYES 2 NO OF DEATH? shows 1 TYES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL Hem 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 □ Inpatient 2 M ER/Outpatient 3 □ DOA OTHER: 1 YES 2 NO te 5 🗆 Residence 6 🗆 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigati E FUNERAL, DIRECTOR: After this d within 72 hours after death wi 1 YES 2 NO 8 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER
//Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE FUNERAL C be filed within 72 h 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFICA 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 목보를 D03599 11-23-94 lesten 9 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md. 21801 32. REGISTRAR'S SIGNATURE men Dendem Randallo

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	t. DECEDENT'S NAME (First, Middle, Last)	T MET	WEN	FOCI	T.				2. DATE OF DEATH MONTH D	AY 100	YEAR	TIME OF DEATH P.
	RUSSEI	S. SEX	VIN	FOGL In yrs. lest birthday					December	6,199		8.72 m
		1 M 2 F	7		MONTHS	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	1010	Country)	ACE (State or Foreign
	214-10-1955 9a. FACILITY NAME (If not institution, give s	/ `	_ 0	4 YRS.	9h CIT	V TOWN	OR LOCATIO	ON OF DI	April 4,		NTY OF DEA	
R	Meridian Health	11.12			100	00	ederi		-AIH	3.00	reder	
5	RESIDENCE OF DECEDENT							Cic				
DIRECTOR	Maryland 10b. count	Frederi	.ck	10c. C	TY, TOWH	OR LOCA	Fr	ede:	rick			Od. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	100. STREET AND NUMBER	Taney	Ave			10	f. ZIP CODE	21	702			at country? States
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO	13	11 yes, sp	CENDENT O	F HISPAI n, Mexica Specif	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		14. RACE -	- American Indian, White, atc. White
IPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		+)	16a. DECEDENT (Give kind o itto. Do NOT Machin	f work done use retired.	during mo	ost of workin	g	16b. KIND OF BU	SINESS/INC		
COMPL	17. FATHER'S NAME (First, Middle, Last)	Albert	Fo	gle			18. MOTH		ME (First, Middle, Maiden	Sumame)	Welty	7
TO BE	19e, INFORMANT'S NAME (Type/Print)	1110010			G ADDRES	S (Street a	and Number		Route Number, City or Tox	vn, State, Zip		
F	Alma F. Fogle			14	21 T	aney	Ave.	/ F	rederick,	Md.	21702	2
	20a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	ovat from Stata		PLACE AND DATE of the start of				v			City or Town	ryland
	21. SIONATURE OF FUNERAL SERVICE LIC	ENSEE		Dinacii	7		ND ADDRES		CILITY			
	(Dayman)	1	12.		1	621	02000		Stauff own Pike/F			
CERTIFICATION	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST	b. DUE TO	(OR AS A	CONSEQUENCE	OF):							Onset and Death
MEDICAL	PART II. Other algnificant condition	-	daath b		-		og cause g	given in	Part i. 24a. WAS APPERFO	RMED?	- 6	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	HOSPITAL:			ОТНЕ	94.			neck only one)			
BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF	F INJURY	28b. T	ME OF	26c. IN.	JURY AT ORK? YES 2		6 Other (Specify) 28d. DESCRIBE HOW	INJURY OC	CURED	
ETED B	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide detarmined	26s. PLACE C building,	OF INJURY , etc. (Spec	— Al home, farm	, street, fa	ctory, offic	ca		261. LOCATION (Street City or Town, State		r or Rural Rou	ute Number,
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYS 2 MEDICAL EXAMINE								to the cause(a) and ma			and menner ea stated.
BE	296, SIGNATURE AND TITLE OF CERTIFIE	1. (~	0	1	٥	29c. LICE	NSE NU	MBER 10587	29d. DAT	E SIGNED (A	Month, Day, Year)
TO	30. NAME AND ADDRESS OF PERSON WE George I. St				oe, Print)		th St	/	Frederick,	Md.		
	31. DATE FILED (Month, Day, Year)	32. REGIŞTRA		ATURE Rode		-						
	DEC 1 2 199	2 Java	an man	WAN BURNE	16							

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

SIC/AN: The law requires that the death certificate be executed within amounts after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
in	tely filled in by	mation, or remo	t, the medica
e executed with	in and complete	to bunal, crem	umatic event
h certificate be	ending physicia	Hygiene prior	or other train
s that the deat	ned by the atte	ifth and Mental	any injury,
he saw require	has been sig	e Dept. of Hea	m 23 shows
PHYSICIAN: TI	this certificate	with the State	rked, or iter
TO THE HOSPITAL OR ATTENDING PHYSICIAI	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with	IMPORTANT: If item 28 is marked,
40SPITAL OR	UNERAL DIR	virhin 72 hou	ANT: If Ites
TO THE !	TO THE F	be filed v	IMPORT

						94	36903	
	1 - FOR STATE REGISTRAR	TATE OF MARYLAND / I	DEPARTMENT OF RTIFICATE OF		NTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)			2.	DATE OF DEATH	YEAR	3. TIME OF DEATH	
1			FISHER	D	ECEMBER 2	, 1994	12 NOON #	
1	4. SOCIAL SECURITY NUMBER 5. SI	Ma De	birthday) IF UNDER 1 YEAR WONTHS DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	Cour	HPLACE (State or Foreign itry)	
	234-38-0519 1 ×	<u> </u>		OR LOCATION OF DEATH	B. 5,1926	9c, COUNTY OF	VA.	
CTOR	6 WAYCROSS CT. P. O	SBURG		FREDER				
DIRECTOR	MARYLAND FREDERI	CK	EMMITSBURG				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	6 WAYCROSS CT.			21727		U.S.		
ВУ	11. MARITAL STATUS 1	WAS DECEDENT EVER IN U.S. ARM FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WW II	IED 13. WAS DE If yes, a	CENDENT OF HISPANIC C pecify Cuban, Mexican, Po S 2 X NO Specify:			CE — American Indian, ck, White, atc. city: WHITE	
E	15. DECEDENT'S EDUCATION (Specify only highest grade comple	leted) (Give	EDENT'S USUAL OCCUPAT a kind of work done during in		16b. KIND OF BUSIN	ESS/INDUSTRY		
LE.	Elementary/Secondary (0-12) Coll	llege (1-4 or 5+)	Do NOT use retired.)		DAIDA			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	PP	ASTEURIZER	18. MOTHER'S NAME (DAIRY First, Middle, Meiden Su	rneme)		
BE C	JAME	S FISHER			MINA ROSS	,		
TO B	190. INFORMANT'S NAME (Type/Print) MARIE FISHER		WAYCROSS C	and Number or Rural Route	Number, City or Town,	State, Zip Code)	RG, MD. 21727	
	20e. METHOD OF DISPOSITION 1	lame of	DATE 20c. LOCA 4/94 SMI	TION — City or 1	Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	Elh.la		AND ADDRESS OF FACILITY				
	> John 111.	siales	210	W. MAIN ST.				
	23. PARM. Enter the disease, or compi ahock, or heart fellure. List of IMMEDIATE CAUSE (Finel disease or condition resulting in death)	olicatione that caused the deapnly one cause Dn each line.	th. Do not enter the m	ode of dying, such as	cardiac or reapiral	oute	Approximate Interval Between Onset and Death	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Due TO (OR &S A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.							
MEDICAL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1/2 YES 2 NO 24b. WERE AUTOPSY FIND OF CAUDE DEATH? 1 YES 2 (X NO							
	DID TOBACCO USE CO	NTRIBUTE TO CAUS	E OF DEATH	YES NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	26, I	PLACE OF DEATH (Check of	nly one)			
14S		Inpetient 2 ER/Outpetient 3 26e. DATE OF INJURY		me 5 X Reeldence 6 U	Other (Specify) 1. DESCRIBE HOW INJ	UEW OCCUPED		
	1 Natural 5 Pending	(Month, Day, Year)	INJURY W	ORK? YES 2 NO	. DESCRIBE NOW INC.	ONT OCCORED		
TED BY		26e. PLACE OF INJURY — At hom building, atc. (Specify)	ie, tarm, street, factory, off	Ca 281	. LOCATION (Street and City or Town, State)	Number or Rural	Route Number,	
COMPLET	and the same of th	To the best of my knowledge, dest					(e) end menner es stated.	
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER	h (a	uallM	29c. LICENSE NUMBER			D (Month, Day, Year) BER 2, 1994	
	30. NAME AND ADDRESS OF PERSON WHO CON ALAN CARROLL, M.D.,	S SETON AVE	FMMITSBIL	RG, MD. 217				
	DEC 05 1994	32. REGISTRAR'S SIGNATURE	arolass.					

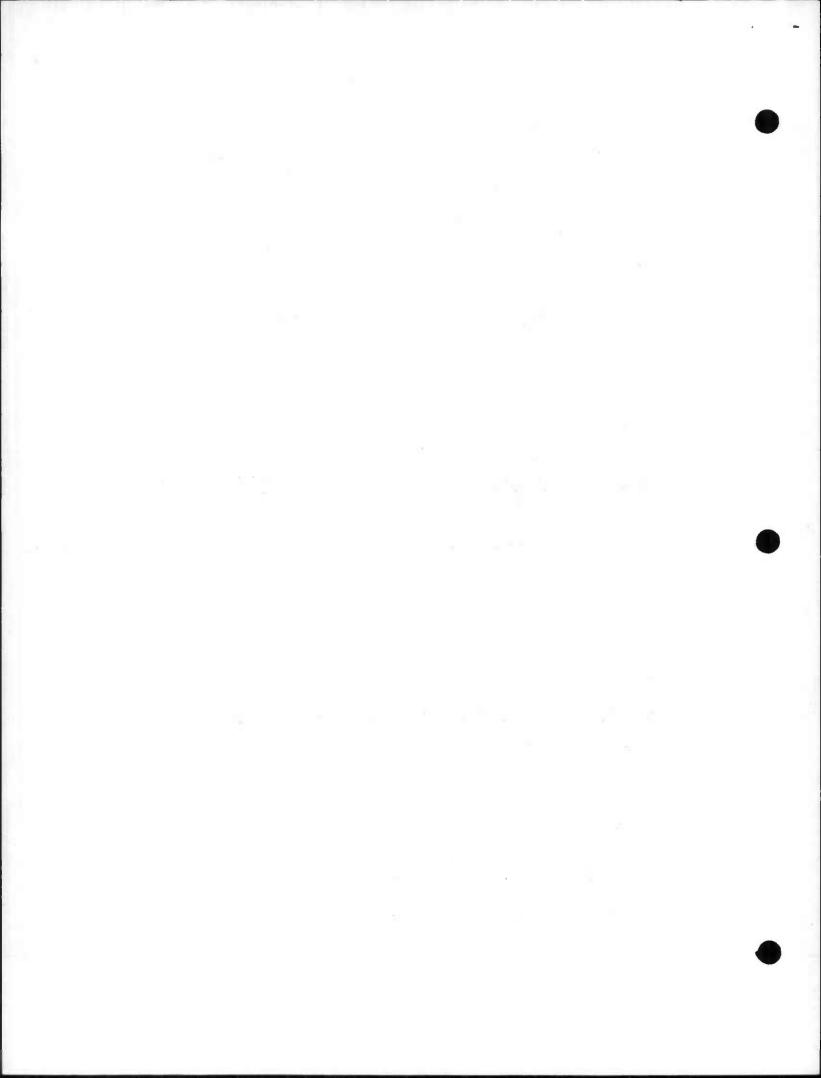
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3ALTIMORE, MARYLAND 21215-0020	or death, Page 6 may be retained by the hospital or attending physician	bunal
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death, Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he filed within 72 hours after death with the State Deat, of Health and Mental Howlene orior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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he law re	e Dent o	m 23 sh
CIAN: 1	ertificati	or ite
ING PHYS	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fire within 72 hours after death with the State Dent of Health and Mental Hynlene prior to burial, cremation, or removal	marked,
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM CERTIFICA	ENT OF H	EALTH AND I	MENTAL HYGIEN			
	DECEDENT'S NAME (First, Middle, Last)	Rollin Frankl	in Fogle			2. DATE OF DEATH	1994 YEAR	3. TIME OF DEATH 2:50 A. M	
i.	4. SOCIAL SECURITY NUMBER 5.			MOER 1 YEAR THS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day Veac) NOV . 19,19	n 8/07	HPLACE (State or Foreign	
TOR	90. FACILITY NAME (If not institution, give atreed Frederick Memorial RESIDENCE OF DECEDENT		9b.		R LOCATION OF DE Frederic	ATH	9c. COUNTY OF	ederick	
DIRECTOR	10a, STATE 10b. COUNTY	lerick		wn on Locat rederi				10d. INSIDE CITY LIMITS? 1X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 512 Military Ro	1.		101.	ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES 2 100			ENDENT OF HISPAN cify Cuban, Maxica 2 NO Specify	Bla	No— 14. RACE — American Indian, Black, White, atc. Specify White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) 7		(Give kind of work of life. Do NOT use reti	flone during mos red.)	N it of working		SINESS/INDUSTRY		
	17. FATHER'S NAME (First, Middle, Last) Walter Rudolph	Fogle	road w	orker		ME (First, Middle, Maiden y Heffner	governme Sumama)	ent	
TO BE	19a. INFORMANT'S NAME (Type/Print) Mary T. Fogle		196. MAILING ADD 512 Mi.	ness (Street at	Rd., Fr	ederick, N	n, State, Zip Code) d. 2170	01	
	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremetton 3 Removal 4 Donation 5 Other (Specify)	from State cemetery	CEAND DATE OF OR	netery		12/1 Mye	ersville		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	oma-		Donald 31 E.	Main St	mpson Fune	own. Md.	e 21769	
TION	23. PART Letter the diseases, or companies. List IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A COR	Ilna. T LYW NSEOUENCE OF):			h as cardiac or resp	fratory arrest,	Approximate interval Between Onset and Daath 13 Months	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST d	DUE TO (OR AS A COR	NSEOUENCE OF):						
AL	PART II. Other significant conditions of		ot rasulting in th	a underiying	cause given in	Part I. 24a. WAS AN PERFOI	RMED?	b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CO				YES NO				
HASIC	1 VES 2 NO 12	OSPITAL: Vinpatient 2 ER/Outpatien 28s. DATE OF INJURY	1 3 □ DOA 4 □	HER: Nursing Home 28c. INJU		8 Other (Specify)			
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WOI		28d. DESCRIBE HOW	NJUNY OCCURED		
- 11	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — A building, atc. (Specify)	it home, farm, street	, factory, office		281. LOCATION (Street City or Town, State)	and Number or Rurei	Route Number,	
COMPLETED		N: To the bast of my knowledge On the basis of examination and						(s) and manner es stated.	
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Roessle	(ms		D204	188	29d. DATE SIGNE	D (Month, Day, Year) 29-94	
	9.1	SUM MED	Po A	30x1	Mig	DILETOW	N, MD	, 21769	
	31. DATE FILED (Month, Day, Year) BEC 0 2 1994	32. REGISTRANS SIGNATUR	Kardalli.						

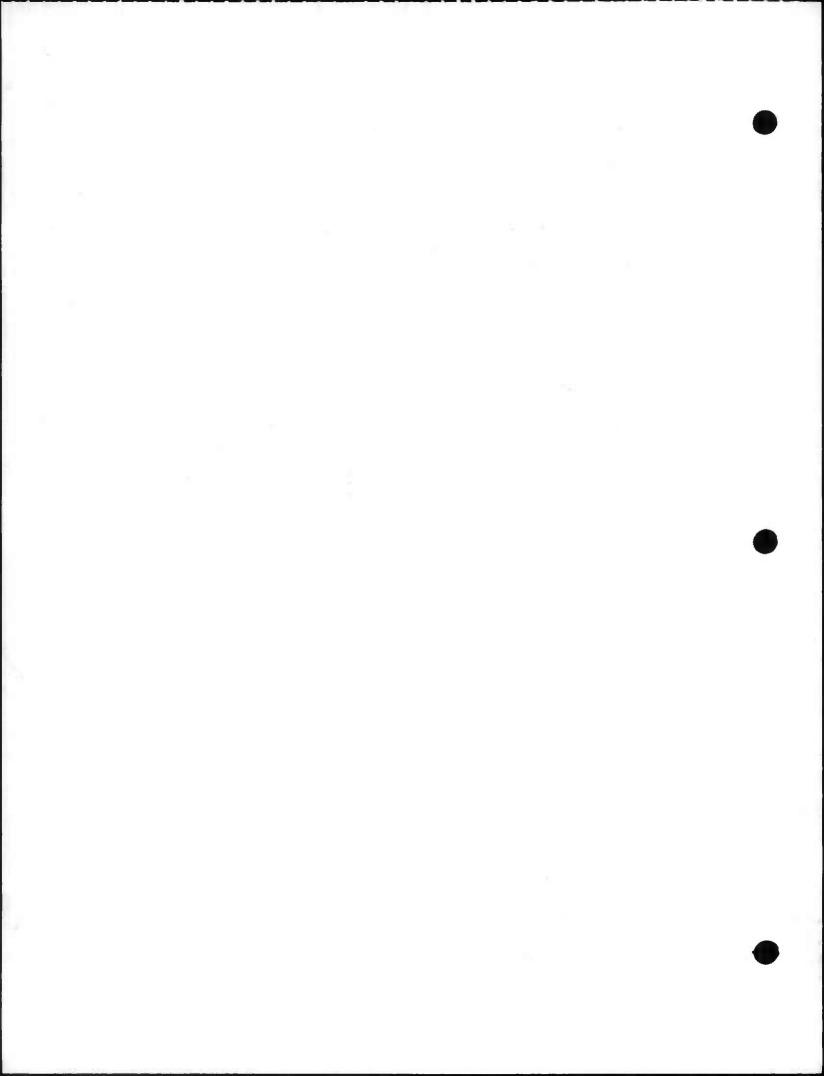


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an order of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH	н
	Mohamad T	•	Faghani	,		November	26 10	YEAR 294	0259	Ам
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			PLACE (State or For	eign
	21/2/0340		U YRS.		HOURS MIN.	Dec.4,	.903	_	ran	
œ	9e. FACILITY NAME (If not institution, give street		9c. COUNTY OF DEATH							
DIRECTOR	Shady Grove Adventist Hospital Rockville MONTGOMERY									
RE	10e. STATE 10b. COUNTY			OWN OR LOCAT	340	10d. INSIDE CITY LIMITS?				
	Maryland Monto	gomery	Gi	aither	1 YES 2 XNO			00		
FUNERAL	948 Windbrooke I	rivo		101	2087	0	10g. CITIZEN OF WHAT COUNTRY?			
UNE	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED			13. WAS DEC		NIC ORIGIN? (Specify		U.S.A.		
	1 Never Married 2 Married	over Married 2 Married FORCES? 1 YES 2 NO			cify Cuban, Maxica 2 NO Specifi	n, Puerto Ricen, atc.)		Black	white, etc.	
D BY	3 X Widowed 4 Divorced						· WIII CC			
TE	15. DECEDENT'S EDUCAT (Specify only highest grade co.	mpleted)	(Give kind of work life, Do NOT use n	done during mo:		16b. KIND OF I	BUSINESS/INDU	STRY		
PLE		College (1-4 or 5+) Lyrs	Farme			Far	m			- 1
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maid	en Surname)			
BE C	Mohamad Faghan:	<u> </u>			Solta	an Fagha	ni			
5	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or 1				
	Rod Faghani					., Gaith				79
	M Maurial 2 ☐ Cremetion 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ol from State Come	tery crematory or other	place)	neof al Dari	OATE 20c.	LOCATION — CI	Char	wn, Stata	^
	21. SIGNATURE OF FUNERAL SERVICE LICEN		A	22. NAME AN	O ADDRESS OF FA	CILITY			il Cii, V	
	Samo 1.	MINIO	11/11			NERALHOM		Α.		
	23. PART i. Enter the Assesses, or cor	ipilcetiona thet ceused	the deeth. Do not	enter the mod	VILLLE, de of dying, suc	MD 208	plratory arre	st.	Approxims	te
	ehock, of heert fellure. Lis	t only one cause on ea	ch line.		all and a fine of				Interval Be Onset and	tween
	disease or condition resulting in desth)	Preur	noma						14 d	ans.
		DUE TO (OR AS A	CONSEQUENCE OF):							7
NO O	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):									
ATI	If any, leeding to immediate cause. Enter UNDERLYING	00E 10 (01 K3 K	CONSCOUENCE OF J.							
ĬĘ.	CAUSE (Disesse or Injury thet initieted eventa	DUE TO (OR AS A	CONSEQUENCE OF):						1	
CERTIFICATION	resulting in death) LAST									
	PART ii. Other significent conditions of	contributing to deeth bu	t not resulting in t	the underlying	ceuee given in		AN AUTOPSY	24b.	WERE AUTOPSY FIN	
PHYSICIAN: MEDICAL						PERF	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CA	
ME									DF DEATH?	
ä	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES		UNCERTAI	N 🗆				
S		IOSPITAL:	6. PLACE OF DEATH (Check only one) THER:						
₹	1 YES 2 NO 1	Ø Inpettant 2 ☐ ER/Outpe	1 28b. TIME O			8 Other (Specify)	V IN II IDV OCCI	IDED		
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	Y WO	RK?	28d. DESCRIBE HOV	Y INJURY OCCU	THEU		
) BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	- At home, ferm, stree		.111	28f. LOCATION (Street		r Rural A	oute Number,	\dashv
TED	4 Homicide determined	building, atc. (Specif	y)			City or Town, Sta	fe)			
PE	29a. CERTIFIER (Check only	N: To the best of my knowle	dge, death occurred a	t the time, date	and pisca, end due	to the cause(a) and n	nanner ae stated	d.		
COMPLET	one) 2 MEDICAL EXAMINER:	On the beals of exemination	and/or investigation, i	n my opinion, de	eath occured at the	time, data end place,	and due to the	cause(a)	end menner as ste	ited.
BEC	299. SIGNATURE AND TITLE OF CERTIFIER	~0	100		29c, LICENSE NUN	men or Gi l			(Month, Day, Year)	\neg
TO B	NA NAME AND ADDRESS OF BERNAM	1			237	011	NOV		194	
	A RATVANO	AH MO	121 C	m)	ional	Ln # 409	Rock	vill	e m02	728V
- 1	31. DATE FILEO (Month, Day, Year)	32 REGISTRAR'S SIGNA Julia Davidson	TURE	0					7	
	NOV 3 n 1994	/ E. //- /	/ [. /s D/3							



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED

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								91	4 3	6906	
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPAR	TMENT ICATE	OF HEALTH AND	MENT	AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) JOSE 4. SOCIAL SECURITY NUMBER	FERRO				NO.	V. 22		YEAR 1994	0210 AM	
	579-62-2999	5. SEX 6. AGE (In yrs. 1	ast birthday)	#FUNDER 1 YEAR #FUNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) July 30,				1942	6. BIRTHPL Country) Spai	ACE (State or Foreign	
OR	98. FACILITY NAME (# not institution, give street and number) Washington Adventist Hospital				96. CITY, TOWN OR LOCATION OF DEATH Takoma Park				9c. COUNTY OF DEATH Montgomery		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN O	R LOCATION				1	Od. INSIDE CITY LIMITS?	
	MD MOI	ntgomery	Si	lver	Spring					X YES 2 NO	
FUNERAL	1400 Rising Wir				20905			Perm		at country? sident	
B≺	11. MARITAL STATUS 1 Never Married 2007 Married 3 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 TYES 2 THE INTERPOLATION OF DATES	IRMED ¶NO	11	NAS DECENDENT OF HIS Yes, specify Cuban, Mex XI YES 2 INO Spe Spanish	Ican, Puart	GIN? (Specify Yea o Rican, etc.)	or No-	14. RACE - Black, \ Specify:	- American Indian, White, atc. White	
뎶	15. DECEDENT'S EDU- (Specify only highest grade	completed)	DECEDENT'S	vork done d		- 1	66. KIND OF BUS	SINESS/IND	USTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Se1f-					erer			
BE CO	17. FATHER'S NAME (First, Middle, Last) Jesus C. Ferro				16. MOTHER'S Merce		t, Middle, Maiden Barros	Surname)			
5	19a. INFORMANT'S NAME (Type/Print) Marillia Ferro	,			(Street and Number or Rui					D 20905	
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremellon 3 Rem 4 Donetion 5 Other (Specify)	oval from State cometery, c		OF DISPOSI	TION (Name of	_	ATE 20c. LO	CATION —	City or Town		
	21, SIGNATURE OF FUNERAL SERVICE 20		01	22. N	NAME AND ADDRESS OF ines-Rinal				SPIII	ig, MD	
	Jours &	Bant		1	1800 New H.	ampsh	ire Ave	sil	ver S	Spring MD	
	23. PART I. Enter the diseases, prosphore, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that caused the class on each life control one on each life control one on each life control on each	death. Do n	ot enter	the mode of dying, s	118	ardiec or reapi	ratory arm	eat,	Approximate Interval Between Onset and Death	
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONS	Tic	/	lou Sma	11 Co	11 Luy	y Con	1101	3moults	
CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	EOUENCE OF	F):							
MEDICAL C	PART II. Other algolificant condition	s contributing to death but not	reaulting i	in the und	derlying cause given	in Part i.	24a. WAS AN. PERFOR	MED?	Al Ci	/ERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
N.	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DE	ATH YE	SIXIN	IO UNCERTA	NN 🗆			'	TYES 2 NO	
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ACE OF DEAT	OTHER							
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Impatient 2 ER/Outpatient 28a. DATE OF INJURY (Month, Day, Year)	26b. TIM		Ing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO	1	her (Specify) ESCRIBE HOW IN	JURY OCC	URED		
TED BY	Accident investigation 3 Suicide a Could not be determined	28s. PLACE OF INJURY — At I building, atc. (Specify)	nome, farm, s	treel, fecto		26f. LC	OCATION (Street a ty or Town, State)	nd Number	or Rural Rou	ite Number,	
COMPLET		CLAN to the best of my knowledge, on the beels of examination and/o								nd manner as stated.	

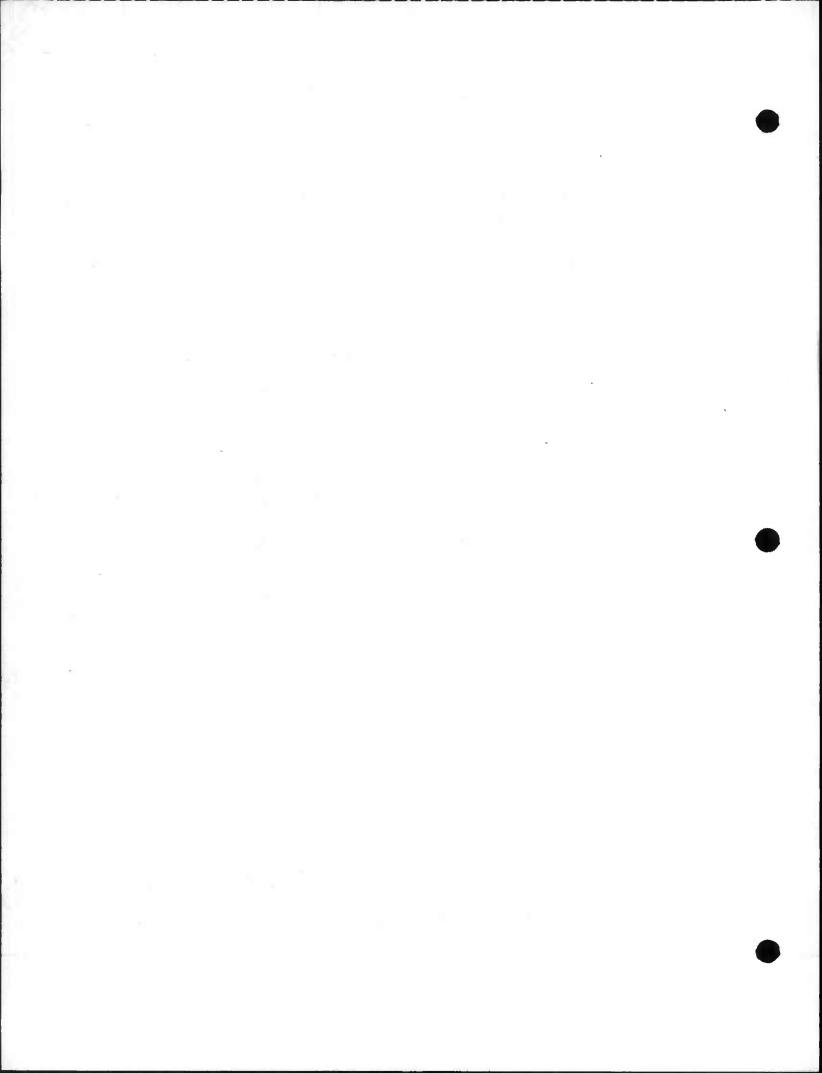
ETED CAUSE OF DEATH (ITEM 27) (Type, Print) Homa

32. REGISTRAR'S SIGNATURE
JUNA DAVIDSON-Randase

29C, LICENSE NUMBER

29d. DATE SIGN

DHMH-18 Rev 1/89



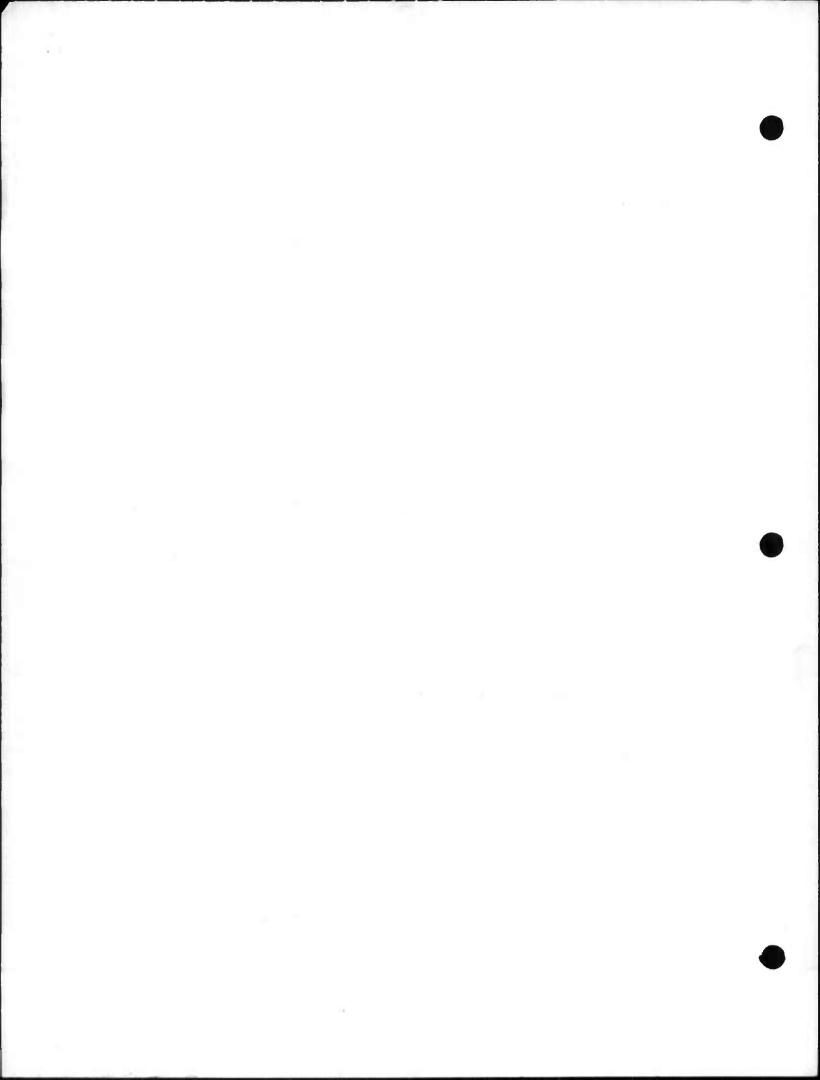
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAN	ID / DEPAI CERTIF					MENTA	L HYGIEN REG. NO	_		
		rrick							MONT		4	YEAR 94	3. TIME OF DEATH 3:15 A M
8	4. SOCIAL SECURITY NUMBER 109-14-2799	5. SEX 1	6. AGE (In y	rs. last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDE	R 24 HRS.	(Mont	OF BIRTH	1909	Country	PLACE (State or Foreign) Sylvania
5	••. FACILITY NAME (If not institution, give st Randolph Hills Nu		me			ato		ION OF DE			9c. COL	nty of DE	EATH
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c. CIT	CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER	Do. STREET AND NUMBER				Silver Spring 101. ZIP CODE				10g. CITIZEN OF WH			
DI FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	Never Married 2 Merried FORCES? 1 YES 2 XNO			l I	f yes, sp	ENDENT ecify Cub	906 OF HISPAN an, Mexica Specify	in, Puerto	f? (Specify Ye Rican, etc.)	s or No—	Specif	— American Indien, , White, etc. y:
COMPLEIED		15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16. KIND OF BUSINESS/INDUSTRY					<u>hite</u>						
L	17. FATHER'S NAME (First, Middle, Lest)	2			Home	make		HER'S NA	ME /First	OW Middle, Malden	n Hor	ne	
2	Martin A. Loftus			19b. MAIL INC	ADDRESS	(Street #		Heler	n Big			in Cartal	
2	Eugene Ferrick			16630									853
	20e. METHOD OF DISPOSITION 1	oval from Stata	ZNOWNEROW	ACEAND DATE	OF DISPOSI	ITION (N)	me of		DAT	E 20c. LC	CATION -	City or Tov	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	lle	ll	Fr	anc	is J	. Col	ciuty 11ins	Fune	ral E	Home,	
	PART I. Enter the diseasea, or cahock, or heert failure. I iMMEDIATE CAUSE (Final disease or condition	List only one cau	ise on each	ine.	not enter	the mo	de of dy	ring, auci	h es cerc	diec or resp	iratory as	rest,	Approximate interval Between Onset and Death
	resulting in deeth)	OUE TO	(OR AS A CO	EBRO DISEQUENCE O	<i>V r9</i> -S Fi:	CU	19E	7+	tRO.	m 805.	5		2 WEEK
	Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO	(OR AS A CO	ONSEQUENCE O	F):								
	that initiated events resulting in death) LAST	DUE TO	(OR AS A CO	INSEQUENCE O	F):								
. 11	PART II. Other algoriticant conditions				In the un	deriying	Ceuse	given in	Pert i.	24a. WAS AN PERFOR	RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE OF E	DEATH (Che	eck only on	e)			
	1 Tes 2 NO	1 inpatient 2	-		-	Ing Hom		eeldence					
	1 Natural 5 Pending Investigation	269. DATE OF (Month, D	lay, Your)	200	M	1 🗆 1	RK? 'ES 2 [NO		CRIBE HOW I			
	3 Suicide 6 Could not be determined	building,	etc. (Specify)	At home, farm,	street, tacto	ory, office			26f. LOC City	ATION (Street or Town, State)	end Numbe	r or Rural Ro	oute Number,
	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE												end manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	L Kri	chu	a) n	0		29c. LIC	ENSE NUM	ABER 4/	ms	29d. DAT	E SIGNED	(Month, Day, Year) 24 1994
	30. NAME AND ADDRESS OF PERSON, WHO	CHMAR	SE OF DEATH	(ITEM 27) (Type 3305/	Print)	£75c	RE	WM	درماء	3210	SILL	cn 5.	Deuxand 2906





3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

French-Asian

20740

Approximata

24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH?

1 YES 2 NO

Onset and Death

Specify:

1 X YES 2 NO

8. BIRTHPLACE (State or Foreign

Vietnam

11:35 P M

BALTIMORE, MARYLAND 21215-0	6 may be retained by the hospital or attending	stor, page 5 should be detached for use as the	nust be notified at once.
	urs after death. Page	r filled in by the funeral direction, or removal.	the medical examiner m
AL RECORDS, P.O. BOX 68760,	he law requires that the death certificate be executed within a Urs after death. Page 6 may be retained by the hospital or attending	s has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the e Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	m 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECOR OR ATTENDING PHYSICIAN: The law requires that

this certificate h marked, or the

After .00 ETED

L DIFFECTOR: A Mours after of I Item 28 is

TO THE HOSPITAL OF THE FUNERAL DE THE FUNERAL DE THE MISSE ZE N. M HOSPITAL

permit, Pages 1, 2, 3 should

physician, burial-transit

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CERTIFICATION

MEDICAL

PHYSICIAN:

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH November 24, 1994 LUCIENNE GILLET FORONDA 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH May 15, 1907 DAYS HOURS 304-58-1839 1 M 2 F 87 9e. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George's College Park 5402 Knoxville Drive RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Prince George's College Park Maryland 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5402 Knoxville Drive 20740 Philippines 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married 3 🖾 Widowed 4 🔲 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elamentary/Seco ndery (0-12) College (1-4 or 5 +) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie (Maiden Name Unavailable) Leopold Gillet 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn F. Miski 5402 Knoxville Drive, College Park, MD 20s. METHOD OF DISPOSITION
1 🖾 Buriel 2 Cremation 3 🗆 Removal from State
4 🗆 Donation 6 🗆 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name DATE 20c. LOCATION — City or Town, State Fort Lincoln Cemetery 11/28/94 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 0 harles F 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final MI grandinan disease or condition_ resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED?

			1 🗆 YE\$ 2 🗆 NO		
5. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (Check only one)		
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DO	OTHER: 4 □ Nursing Home 6 ☑ Residence	e 6 ☐ Other (Specify)		
7. MANNER OF DEATH 1 Netural 6 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	TIME OF 18c. INJURY AT WORK? M 1 YES 2 NO	28d. DEȘCRIBE HOW INJURY OCCURED		
3 Suicide 6 Could not be	28e. PLACE OF INJURY — At home, fair building, etc. (Specify)	rm, street, factory, office	261, LOCATION (Street and Number or Rural Route Number, City or Town, State)		

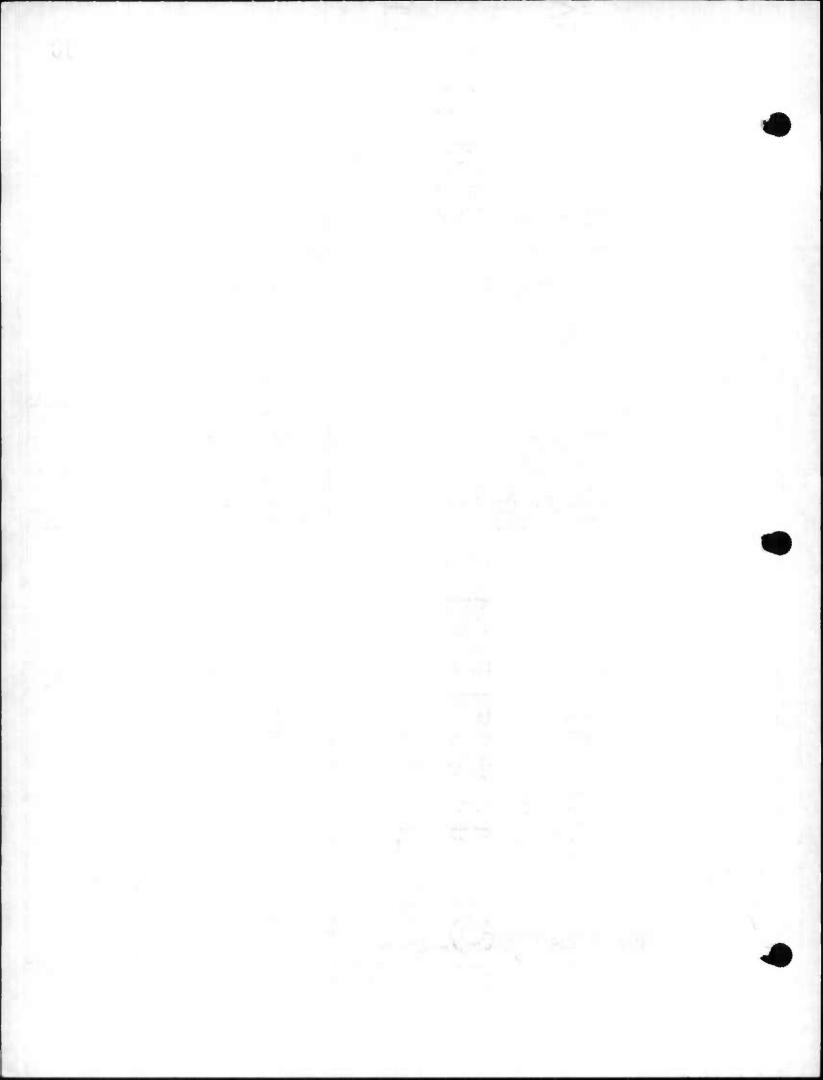
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER SUITED SUITED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 14216

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Prigt) noul Van: MBBIGMD 6514

32. RESISTRAR'S SIGNATURE Fundall

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DIVISION OF VITAL RECORDS	
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		REGISTRAR t. DECEDENT'S NAME (First,	, Middle, Leat)			ENTIFF	CAIL O	F DEATH	2. DATE OF D	EATH			3. TIME OF	DEATH
		71:00	Maria	Fillha	n+				HTHOM	DAY		YEAR		
	H	A SOCIAL SECURITY NUMBER	Marie	5. SEX	6. AGE (In yrs. Is	net hietholms	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B		994		1:30	
		232-38-5	347	1 M 2 F	74	· · ·	MONTHS DAYS		Dec.	Year)	919	Count	st Vi	
		9a. FACILITY NAME (If not in	natitution, give	street and number)			9b. CITY, TOW	N OR LOCATION OF				NTY OF D		
CTOR		Meridian		Creek			1	Annapol	is		Ann	ne A	runde	el
DIREC	I	10s. STATE	10b. COUNT	ry		10c. CITY	TOWN OR LO	CATION	-				10d. INSIDE	CITY
		Maryland	Qu	een Ann	e's	5	Stever	nsville					1 TYES	
ERAL		10e. STREET AND NUMBER						101. ZIP CODE			10g. CITI	ZEN OF V	WHAT COUNT	RY?
6		513 Broad	dcree	k Dr.				21666		- 1		U.S	. A .	
BY FUN		11. MARITAL STATUS 1 Never Married 2 1		FORCES?	NT EVER IN U.S. A 1 YES 2 X WAR OR DATES	RMED NO	If yes,	Specify Cuban, Mexi ES 2 NO Spec	can, Puarlo Rican.		or No-		E — American k, Whita, etc.	
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1 11	1	(Specify only	y highest grad		1 (ork done during	most of working	16b. KIN	OF BUSI	NESS/INC	DUSTRY		
1 2		Elementary/Secondary (0	0-12)	College (1-4 or 5	+)		-							
COMPLET	-	17. FATHER'S NAME (First, M	eratura e si			Homen	ıaker			377				
Ш	10 2	Franklin E		min Ban	croft				IAME (First, Middle L Jane					
m	- 10-	190. INFORMANT'S NAME (7	Type/Print)		1	9b. MAILING	ADDRESS (Street	nt and Number or Rurs	Il Route Number, Ci	ty or Town,	State, Zic	Code)		
2	I	Deborah Cl	larke					472, St					2166	6
		20a. METHOD OF DISPOSITI	TON				DISPOSITION	·		20c. LOC				
1	н	· Kil	L SERVICE LI	DI DI	Ste	vensu	22. NAME	Cemeter AND ADDRESS OF I Helfer	FACILITY		tev		ville mes,	•
		23. PART I. Enter the di	Hooses, or leart fellure.	Velle	nfee	leath. Do no	TON	AND ADDRESS OF I	radum nbein E	une C	ral hes	Ho	Mes,	P.A 21 eximats ai Betwe
CERTIFICATION		23. PART I. Enter the di shock, or h IMMEDIATE CAUSE (Fir disease or condition	vecases, or leart fellure.	complications this Liet offly one co	nfee	leath. Do not let. Low EQUENCE OF	22. NAME TON 106 of enter the r	AND ADDRESS OF I	radum nbein E	une C	ral hes	Ho	Mes,	P.A. 216 eximats ai Between
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MEDICAL CERTIFICATION		23. PART I. Enter the dishock, or himmediate CAUSE (Fir disease or condition resulting in death) Sequentially list condition in the cause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS PART II. Other significant conditions in the cause.	itions, idiate inny conditions.	b. DUE TO d	at caused the duse on each line O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O death but not	EOUENCE OF	22. NAME TON 106 of enter the r	AND ADDRESS OF IN Helfer Shamronode of dying, su	n Part I. 24e.	Sor respiri	ral hes mtory en	Hoi ter rest,	Mes, Appre interv Onset 3 WERE AUTOP MAILABLE PI COMPLETION OF DEATH?	P.A. 21. oximats ail Betweet and Decision of the Park Strain of the Park Strain oxidate oxidat
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PHYSICIAN: MEDICAL CERTIFICATION		23. PART I. Enter the dishock, or himmediate CAUSE (Firdlesses or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) LAS PART II. Other signification in death) DID TOBACC 15. WAS CASE REFERRED TO EXAMINER? 1 YES NO 17. MANNER OF DEATH Netural 5	itions, idiate inny conditions.	b. DUE TO C. DUE TO C. DUE TO DIE T	at caused the duse on each line O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI EXPLORMENT EXPLORMENT EXPLORMENT FINJURY	EQUENCE OF) COUNCE OF) COUNCE OF) COUNCE OF) COUNCE OF) COUNCE OF)	the underly DEATH 26. I Nursing H OF 28c. I R 22. NAME TOR 1 0 6 1 0 6 1 0 6 1 0 6 1 0 6 1 0 6 1 0 6 1 0 6 1 0 7 0 7 0 7 1 0 7 1 0	AND ADDRESS OF IN Helfer Shamro mode of dying, su Fall of the state of	n Part I. 24a.	WAS AN A PERFORM YES 2	ral hes more on the second of	Holiter rest,	Mes, Appre interv Onset 3 WERE AUTOP MAILABLE PI COMPLETION OF DEATH?	P.A. 21. Oximats ail Betweet and Delta Place are all Personal Place are all Place are
ED BY PHYSICIAN: MEDICAL CERTIFICATION		23. PART I. Enter the dishock, or himmediate Cause (Fir disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or injusting in death) LAS PART II. Other signification intieted events resulting in death) LAS DID TOBACC 15. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 18. Netural 5 2 Abeldent 2 Abeldent 3 Suicide 8	Jeseases, or leert fellure. In all the learning of the learnin	b. DUE TO d. CONTRIBU HOSPITAL: 1 Inpetient 2 288. PLACE 0	at caused the duse on each line O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI O (OR AS A CONSI EXPLORMENT EXPLORMENT EXPLORMENT FINJURY	POUENCE OF	the underly DEATH 20. Nursing H OF ER: M 1 1	Ing couse given in the course given in the couse given in the cour	n Part I. 24a.	WAS AN A PERFORM YES 2	untopsy MED?	HOI ter rest,	Mes, Approinterv Onset 3 WERE AUTOP AMAILABLE P COMPLETION OF DEATH? 1 YES 2	P.A. 21. Oximats ail Betweet and Delta Place are all Personal Place are all Place are
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MPLETED BY PHYSICIAN: MEDICAL CERTIFICATION		23. PART I. Enter the dishock, or himmediate CAUSE (Fir disease or condition resulting in death) Sequentially list condit: If any, leading to immediate cause. Enter UNDERLY! CAUSE (Disease or injuthat initiated events resulting in death) LAS PART JI. Other signification of the condition of the cause in the cause in the cause in the cause in the cause in the cause in the cause of the cause in the cause i	Seases, or seert fellure. In all the seases, or seases, or seert fellure. In all the seases, or seert fellure. In all the seases, or seert fellure. In all the seases, or seas	b. DUE TO d. CONTRIBU HOSPITAL: 1 Inpatiant 2 28a. PLACE of building	at caused the duse on each find of the constant of the constan	EOUENCE OF) Tresuiting in USE OF 28b. TIME INJUINGMENT, set	22. NAME TON 1 0.6 It enter the r Comments Nursing H OF 28c. I Treet, factory, of	Ing couse given in YES PLACE OF DEATH (Come 5 Rasidence NJURY AT WORK? YES 2 NO ffice	n Part I. 24a. The Check only one) B Check only one) B Check only one) 28d. DESCRIB	WAS AN A PERFORM YES 2 I (Street an m, State) and menn	untopsy AED? NO UNITOPSY AED? NO Output Oct And Number	HOI ter rest, 24b	Mes, Approintervionsel Approin	P.A. 21. oximats ail Betweet and De. Year Property of Cause of Cau
MPLETED BY PHYSICIAN: MEDICAL CERTIFICATION		23. PART I. Enter the dishock, or himmediate CAUSE (Fir disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or injusting in death) LAS PART JI. Other signification resulting in death) LAS PART JI. Other signification resulting in death) EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Actident 3 3 Suicide 8 4 Homicide CERTIFIER Certification resulting in MEDI	per conditions, dieter ing investigation Could not be determined	b. DUE TO d. DUE TO DUE T	at caused the duse on each find of the constant of the constan	EOUENCE OF) Tresuiting in USE OF 28b. TIME INJUINGMENT, set	22. NAME TON 1 0.6 It enter the r Comments Nursing H OF 28c. I Treet, factory, of	Ing couse given in YES PLACE OF DEATH (Come 5 Rasidence NJURY AT WORK? YES 2 NO ffice	n Part I. 24a. The Check only one) B Check only one) B Check only one) 28d. DESCRIB	WAS AN A PERFORM YES 2 I (Street an m, State) and menn	untopsy AED? NO UNITOPSY AED? NO Output Oct And Number	HOI ter rest, 24b	Mes, Approintervionsel Approin	P.A. 21. Oximats at Between and De A. P.A. P.A. P.A. P.A. P.A. P.A. P.A.
OMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION		23. PART I. Enter the dishock, or himmediate CAUSE (Fir disease or condition resulting in death) Sequentially list condit: If any, leading to immediate cause. Enter UNDERLY! CAUSE (Disease or injuthat initiated events resulting in death) LAS PART JI. Other signification of the condition of the cause in the cause in the cause in the cause in the cause in the cause in the cause of the cause in the cause i	per conditions, dieter ing investigation Could not be determined	b. DUE TO d. DUE TO DUE T	at caused the duse on each find of the constant of the constan	EOUENCE OF) Tresuiting in USE OF 28b. TIME INJUINGMENT, set	22. NAME TON 1 0.6 It enter the r Comments Nursing H OF 28c. I Treet, factory, of	Ing couse given in YES PLACE OF DEATH (Come 5 Rasidence NJURY AT WORK? YES 2 NO ffice	n Part I. 24a. The Part I. 24	WAS AN A PERFORM YES 2 (Street and menn placa, and	urtopsy AED? NO JURY OCC de Number dua to the	HOILTER 24b CURED or Rural F	Mes, Approintervionsel Approin	P.A 21 ximats ail Betweet and De year sy Finding rion To Of Cause Ano

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D

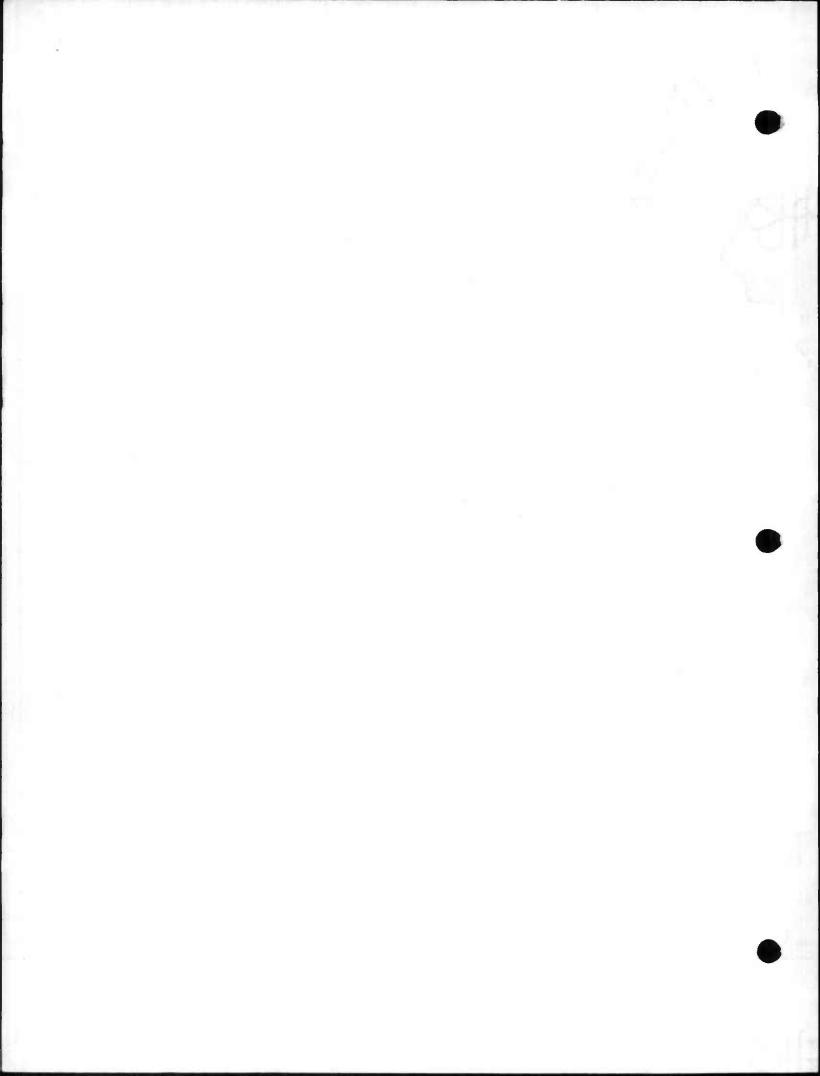
1833-A

32. BEGISTHATTO SIGNATURE

Forest Dr., Annapolis,

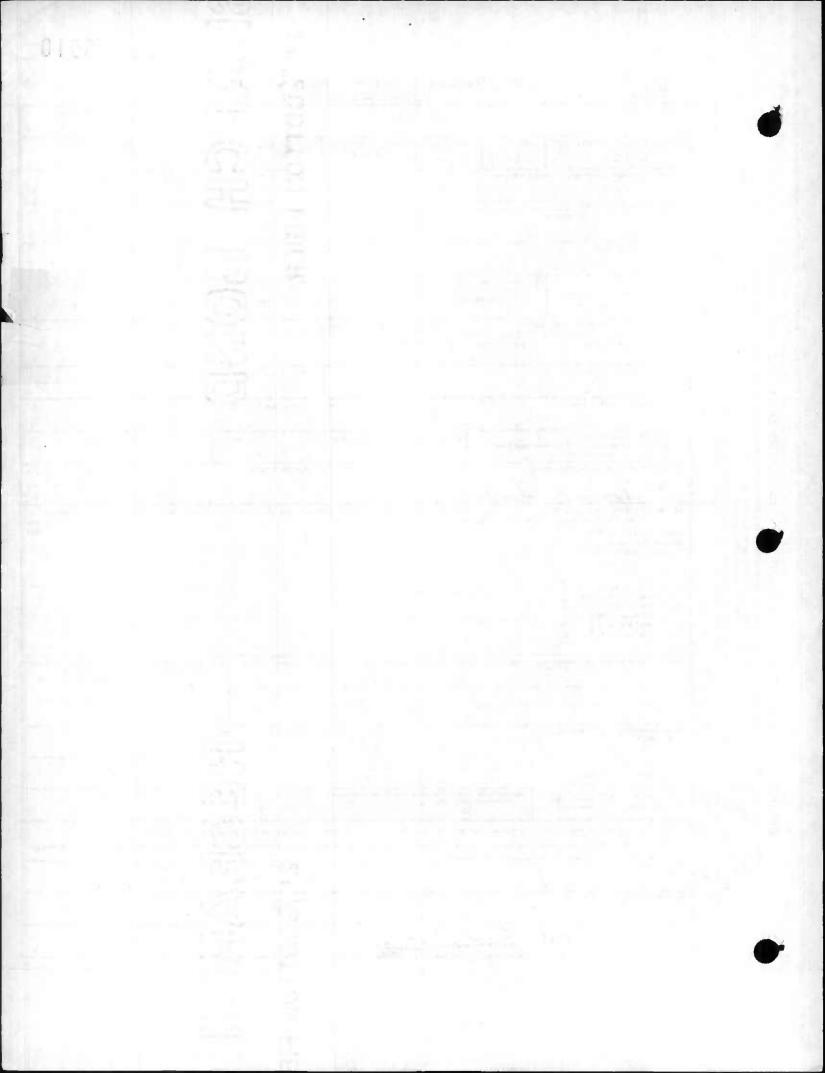
Peter Verkow,
31. DATE FILED (Month, Day, Year)
NOV 9 1994

Md.



STATE OF	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
	C	ERTIFICATE	0	F DEAT	TH		REG. NO.

	REGISTRAR		CERTIF	FICATE O	F DEATH	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last,					2. DATE OF DEAT		3. TIME OF DEATH		
	Ethel Dulin	Fleming				Nov 7	1994	6.20 P		
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AC	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		. BIRTHPLACE (State or Foreign		
	218-20-5681	1 M 2 N F	95 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Yea	11)	Country)		
	9a. FACILITY NAME (If not institution, give	street and number	73	ah CITY TOWN	N OR LOCATION OF D	June 2				
OC.					Queen Anne ts					
2	Corsica Hills Nursing Center Centreville Quee									
L DIRECTOR	100. STATE 10b. COUNT	ry	10c. Cr.	TY, TOWN OR LOS	PATION			10d. INSIDE CITY		
	Manuland	7 mm - 1		111111111111111111111111111111111111111				LIMITS?		
		ueen Anne	S S	tevens				1 TES 2 THO		
₹	10e. STREET AND NUMBER				101. ZIP CODE			N OF WHAT COUNTRY?		
9	8210 Romanc	oke Road			21661			U.S.A.		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED		ECENDENT OF HISPA		y Yes or No- 1-	4. RACE — American Indian, Black, White, etc.		
	1 Never Married 2 Married	FORCES? 1 Y	R DATES		specify Cuban, Mexico ES 2 XIV Specia		.)	Specify: White		
B₹	3 Widowed 4 Divorced	T-1-10			37.37			MILLE		
ETED	15. DECEDENT'S ED		16a. DECEDENT'S	S USUAL OCCUPA	TION	16b. KIND OF	BUSINESS/INDUS	STRY		
<u> </u>	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	work done during use retired.)	most of working					
립	8	College (1-4 of 5 4)	Wait	ress		1000	Food			
COMPL	17. FATHER'S NAME (First, Middle, Lest)				18 MOTHER'S N					
		lin			and the second second second	ME (First, Middle, Ma sie Ken				
BE	Harry B. Du	T T I I								
0	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural					
-	William Moore		821	0 Roma	ncoke R	d.,Stev	ensvil	le, Md.216		
	20a. METHOD OF DISPOSITION		206. PLACE AND DATE			DATE 200	LOCATION - CH	ty or Town, Stata		
	1 Donation 5 Other (Specify)	noval from State	Cemetery, cremetory or	other plece)	Nov	. 10, 1	994			
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	Greenmo	22. NAME	Metery AND ADDRESS OF FA	CILITY	H1	llsboro, I		
	M/ 1	,5//	/				neral	Homes, P.A		
	Chomas K.	Hellen	Marie.					r, Md. 216		
	23. PART I. Enter the diseases, or	complications that cau	sed the deeth. Do	not enter the r	node of dying, suc	h as cardiec or r	eapiratory arres	st, Approximate		
	shock, or heart fellure. List only one cause on each line.									
	iMMEDIATE CAUSE (Final disease or condition		()	201	12			Onset and E		
	resulting in death)	8	u) 00	~			Pyr.		
		DUE TO (OR A	S A CONSEQUENCE O	OF):				1		
Z	Sequentially list conditions,	b						v		
Ĕ	if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE C	DF):						
3	CAUSE (Disease or Injury	G								
CERTIFICATION	that initiated events	DUE TO (OR A	S A CONSEQUENCE O	OF):						
E	resulting in death) LAST	d								
5										
A	PART ii. Other aignificant condition	ns contributing to deet	h but not resulting	in the underly	ing ceuse given in	Part I. 24s. WA	S AN AUTOPSY	24b. WERE AUTOPSY FING MAILABLE PRIOR TO		
EDICAL							S 2 NO	COMPLETION OF CAL		
						_ '''	3 1 / 10	OF DEATH?		
Σ								1 TYES 2 NO		
AN										
ठ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		QTHER:	PLACE OF DEATH (C/	neck only one)				
1SI	1 TES 2 NO	1 Inputient 2 ER/C	Outpatient 3 DOA	Nursing H	ome 5 🗆 Rasidence	6 Other (Specify)				
PHYSICI	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Yes	RY 28b. Til	ME OF 28c.	NJURY AT	28d. DESCRIBE H	OW INJURY OCCU	RED		
ВУ	1 Natural 5 Pending		, , ,		YES 2 NO					
	2 Accident Investigation 3 Suicide S Could not be	28a. PLACE OF INJU	URY — At home, ferm,	street, factory, of	fice			Rural Route Number,		
9	4 Homicide determined	building, etc. (S	specify)			City or Town, S	State)			
	29e. CERTIFIER									
COMPL	(Check only CERTIFYING PHY	SICIAN: To the best of my kr								
S	one) 2 MEDICAL EXAMIN	IER: On the beels of axamina	ation and/or investigati	ion, in my opinion	, death occured at the	time, data and plac	a, and dua to the	cause(s) and manner as stat		
	296. SIGNATURE AND TITLE OF CERTIFI	ER /	1		29c. LICENSE NU	MBER	29d DATE S	SIGNED (Month, Day, Year)		
BE		/ /			0125					
ш]	>d.	1 -1								
	Aleu	1 Drie	2/		0/00		140	ov. 9,1994		
TO B	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	DEATH (ITEM 27) (Typ	e, Print)	3/20		140	ov. 9,1994		
	Aleu							- 1414-5		
	30. NAME AND ADDRESS OF PERSON W JOHN R. Smit 31. DATE FILED (Month, Day, Vear)	h, Jr.	M.D. /20	7 N. L	iberty S			- 1414-		
	30. NAME AND ADDRESS OF PERSON W	h, Jr.	M.D. /20	7 N. L				+144-51-		



ID THE HUSH ML OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 2- hours after death. Page 6 may be retained by the hospital or attending physician.

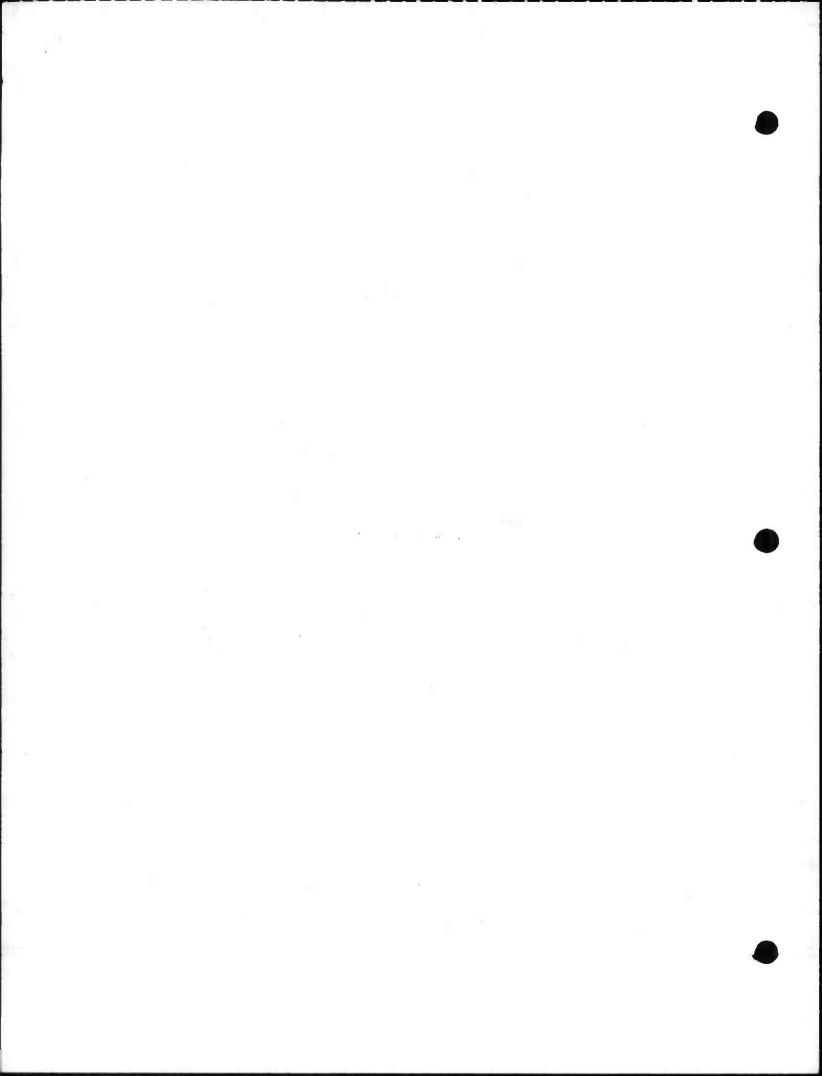
ID THE FUNEAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rear within 7 hours after death with the State Dept. of Health and Mental Hygher prior to burial, cremation, or removal.

IN PORTANT II them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be natified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_[1. DECEDENT'S NAME (First	Addedd Local					0	רבת	· · ·		EG. NO.			
1	1		_			-					2. DATE OF C	DA		YEAR	3. TIME OF DEATH
-		Robert		merson			schm				Nov.	26	19	94	10:55 p м
-		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (III	n yrs. leal birth	MONT	HS DAYS		R 24 HRS.	7. DATE OF E (Month, De			6. BIRTH Countr	PLACE (State or Foreign
1		214-07-812	3	1 🔀 M 2 🗌 F	19	Y	RS.		Moons		June 2		15		yland
1		9e. FACILITY NAME (If not in	estitution, give s	treet and number)			9b.	CITY, TOWN	OR LOCAT	ON OF DE	ATH		9c. COU	NTY OF D	EATH
	DIRECTOR	The Memor		spital				Eas	ton				T	albo	t
	5	RESIDENCE OF DEC	10b. COUNTY												
	뿔					100	c. CITY, TO	VN OR LOC		.1				- 1	10d, INSIDE CITY LIMITS?
		Maryland		rchester					Can	brid	ge				1 YES 2 NO
	¥	10e. STREET AND NUMBER						1	of. ZIP COD	_					VHAT COUNTRY?
1	單	213 Ram	bler R	oad	_				4	21613				U.S.	Α.
1	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN						IC ORIGIN? (S		or No-	14. RACE	— American Indian, r, White, etc.
1	ВУ	1 Never Married 2 X 3 Widowed 4 Divo		World	MAR OR DA	TES			S 2 X NO			i, accep			white
ŀ					wai 2										
1	1	(Specify only	EOENT'S EDUC y highest grade			16e. DECEDE	ent's usua	L OCCUPATION OF THE PROPERTY O	TION nost of worki	ing	16b, KIN	D OF BUS	INESS/IN	DUSTRY	
-	ا ت	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	cold					froz	on f	hoo	prod	uction
, i	COMPLETED					COId	SLUI	ige iii	_	_				prod	detion
5	8	17. FATHER'S NAME (First, M Fra		eischman					16. MOT		ME (First, Middle race	Page			
2	BE			erschhan											
	2	190. INFORMANT'S NAME (7		1		19b. MA					loute Number, C				
2		Mrs. Netti		schman			213	Kambi	er Ko	1., 0	ambrid	ige r	וט צו	.013	
	ŀ	20e. METHOD OF DISPOSITI	n 3 🗆 Rame	ovat from State	20b.	PLACE AND D	OATE OF DIS	POSITION (Name of		DATE	20c. LO		City or To	
		4 Donation 5 Dother			_ Do	orches	ster 1				11/29	Сап	ibrid	ige M	aryland
	1	21. SIGNATURE OF FUNERA				1		22. NAME	AND ADDRE	SS OF FAC	Th	omas	Fun	eral	Home
CAG		Ren	neth	R The	- Andrew	- h.		700	Locus	st St	., Cam	brid	lge M	ID 21	613
		23. PART I. Enter the di	iseasea, pro	omplications the	t caused	the death.	Do not e								Approximate
		ahock, or hi		List only one car	iae on ea	ch line.									Interval Between Onset and Death
		disease or condition_			1	14.	000	0	0.	- 8	retu	4.			6 400
		resulting in death)		QUE TO	(OR AS A	CONSCIUEN	CE OF):	XIA	K.	4	NCIL		<u></u>		BILL
5	-					0				U					Ĺ
	CERTIFICATION	Sequentially list conditi if any, leading to imme-	iona,	DUE TO	(OR AS A	CONSEQUEN	CE OF):								
	§ I	cause. Enter UNDERLY	NG .												
	Ĕ	CAUSE (Disease or Inju that initiated eventa		DUE TO	(OR AS A	CONSEQUEN	CE OF):								
		reaulting in death) LAS	T .	d											
		DART II Other shoulder	-1	U1 - 1 - 1 - 1											
	EDICAL	PART ii. Other algnifica						-0	ng cause	given in F	Part I. 24e	PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
	ă	There				evous	Ny C	ula	Usas	20	10	YES 2	NO		OF DEATH?
	M	Dialie		welle		Gar	igrpin	20 e	toe s	(R)					1 - YES NO
	ż	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH	YES [ON [UNC	CERTAIN)B				~
	S	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	2	6. PLACE OF)						
	Š	1 TES 2 NO		1 Inpatient 2	ER/Outpa	ntlent 3 🗆 D		fER: Nursing Ho	me 5 🗆 R	esidence (6 Other (Sp	eclfy)			
	PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, D		286	TIME OF	28c. II	JURY AT		28d. DESCRIE	BE HOW IN	JURY OC	CURED	
	BY		Pending Investigation		_,,,		1	. 1	YES 2] NO					
	EDE	3 Sulcide 6	Could not be	28e. PLACE C	F INJURY -	— At home, for	arm, street,	factory, off	Ice		261. LOCATIO	N (Street a	nd Number	r or Rural R	loute Number,
	ETE	4 Homicide	datarmined	in							Only or 10	W/1, O(310)			
	2	290. CERTIFIER	TEYING PHYSI	CIAN: To the best of	my knowle	dga, daeth o	courred at t	he time, da	ta end place	, end due t	to the causele) end man	ner ae sta	ted.	
	COMPL) end manner ee stated.
		THE SIGNATURE AND TITLE								ENSE NUM		1			(Month, Day, Year)
	8	Aduna	D.	5-11.00	1 1	INA	\cap		D	270	09		▶ / I	1.2	7.90
1		30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAU	SE OF DEA	TH (ITEM 27)	(Type, Print)			/ -	1				17
1	H	606	シゴ	chuan	u C	Que	6	ASI	BA/	1	11	21	60	7	
		31. DATE FILED (Month, Day,	Year)	42 REGISTRA	R'S SIGNA	DHE		, 1-1	0		- 2//	011		+	
		MUA 3 0	1994	Julia d'au	where	wordall									
-				-											



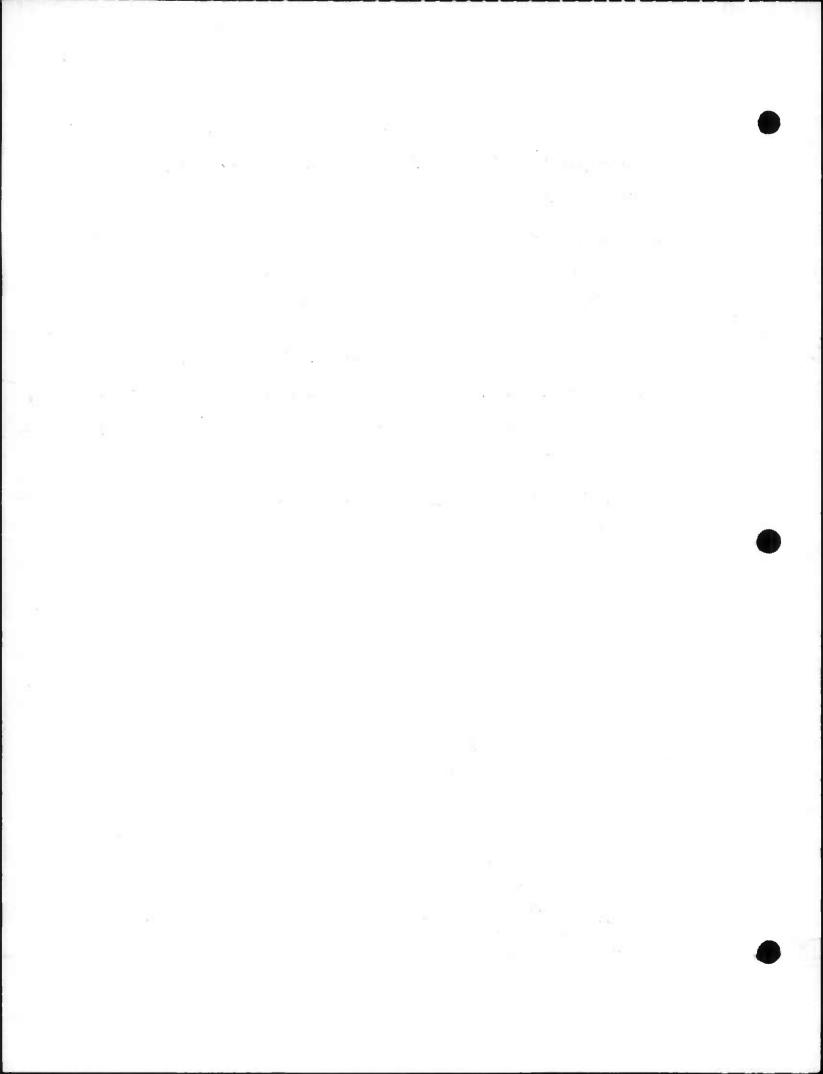
DRE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitled at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEI		
1	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Geo	rge T. Feese	r		MONTH - 2	YE - 9	4 10409
	The soul of the Average			UNDER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	217-70-1004		80 YRS.		Feb. 7, 19.		nknown
OT.	99. FACILITY NAME (If not institution, give stre Carroll County			Westminster	DEATH	9c. COUNTY	of DEATH rroll
DIRECTOR	RESIDENCE OF DECEDENT	- HOSPItal		wesummster		Va	11011
JEC.	10e. STATE 10b. COUNTY			WN OR LOCATION			10d. INSIDE CITY
	MD Carr	011	T	aneytown			LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 2718 Black	s Schoolhous	e Rd.	101. ZIP CODE 21787	7		OF WHAT COUNTRY?
N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DECENOENT OF HISPA		e or No— 14.	RACE — American Indian,
BY F	1 X Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, specify Cuben, Mexic 1 ☐ YES 2 ☐ NO Spec			Black, White, etc. Specify:
	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S USU	AL OCCUPATION	Test Kills of all		WHite
ETE	(Specify only highest grade co	ompleted)	(Give kind of work	done during most of working	16b. KIND OF BL	ISINESS/INDUST	RY
PL	Elementary/Secondary (0-12)	College (1-4 or 5+)	Farm La	borer	Farmin	ng	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Maldel		
BE	Milton E. Fe	eser		Lol	La Schaeffe	er	
6	19a. INFORMANT'S NAME (Type/Print) Miriam W. Young		196. MAILING ADD 2.718	RESS (Street and Number or Rural Blacks School	House Rd.	Vn. State, Zip Coo	own MD 21787
	20%/METHOD OF DISPOSITION		PLACE AND DATE OF DI			OCATION — City	
	1 ☑ Buriel 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)			irch Cemetery			nster, MD
-	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AND ADDRESS OF F			ttlestown, PA
	* Ruhal o	Live (1	Little's F.H.	. 34 Maple		17340
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	mplications that caused	the death. Do not a	nter tha moda of dying, su	ch as cardiac or reas	lratory arrest.	
	IMMEDIATE CAUSE (Final	N/ cha cause on as			٨		interval Between Onset and Daath
	disease or condition reaulting in death) a.	Ventin	cular	oncho pre	ale		Ingland
		DUE TO (OR AS A	CONSEQUENCE OF):		^ -		
CERTIFICATION	Sequentially list conditions, b.	OUE TO (OR AS A C	CONSEQUENCE OF:	aveno bus	MOMO	1	
CAT	if any, leading to immediata cause. Enter UNDERLYING						į l
Ē	CAUSE (Disesse or injury that initiated avents	DUE TO (OR AS A	CONSEQUENCE OF):				
EH	resulting in death) LAST						
AL C	PART ii. Other algnificant conditions	contributing to death bu	not resulting in th	a underlying cause given in	Part i. 24e. WAS AF	AUTOPSY	24b. WERE AUTOPSY FINDINGS
				1 21 27	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 □ YES	2 [] NO	OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	□ NO □ UNCERTAI	N D	ĺ	T TES 2 NO
IAI	25. WAS CASE REFERRED TO MEDICAL	20	B. PLACE OF OEATH (C	heck only one)			
YSIC		HOSPIPAL:		HER: Nursing Home 5 Residence	6 Other (Specify)		
H	27. MANNER OF SEATH	28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUR	ED
B⊀	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO			
COMPLETED	3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF INJURY - building, atc. (Specif)	- At home, larm, atreet	, factory, office	28f. LOCATION (Street City or Town, State		tural Route Number,
E	29s. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the heat of my knowled	for death occurred at	the time, date end pieca, and du-	4 4 4 4		
M M				my opinion, death occured at the			use(s) end menner as stated.
	29b BRONATURE AND TITLE OF CERTIFIER			29c. LICENSE NU			
B	Colvita led	1 Maca	w-e	DI C	200	DATE SIG	GNED (Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Print			1	30-12
	CHITRACHED	U NAC			oole Rd	west	milute 1708/157
Ĭ.	JEU 05 1994 July	32. REGISTRAR'S SIGNAT	URE				

The second section

		REGISTRAR		ATE OF DEATH	WEN IAL HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest) JANET	GURZICK		2. DATE OF DEATH DAY DECEMBER O	6 100/	3. TIME OF DEATH 1:58 P M
-		4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birthday) #	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		PLACE (State or Foreign
pinc		362-48-1714 1 M 2 XF 9a. FACILITY NAME (If not institution, give street and number)	AP YRS.	NTHS DAYS HOURS MIN.	11/5/4	7 m	ichigan
2, 3 should	S S	THE JOHNS HOPKINS HOSPIT		CITY, TOWN OR LOCATION OF DE ALITMORE CITY	ATH	P. It.	more
Pages 1, 2	DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		DWN OR LOCATION		10-16	10d. INSIDE CITY
permit. Par		Maryland Frederick	Fred	ferick_			LIMITS? 1 YES 2 NO
	ERAI	100. STREETAND NUMBER	~	101. ZIP CODE		10g. CITIZEN OF W	HAT COUNTRY?
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS 12. WAS DECEDEN	T EVER IN U.S. ARMED	13. WAS DECENDENT OF HISPAN If yes, specify Quban, Maxican	IIC ORIGIN? (Specify Year	or No- 14, RACE	- American Indian, White, atc.
e ge	B	3 Widowed 4 Divorced IF YES, GIVE W		1 TES 2 NO Specify		Specif	
	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USU (Give kind of work	done during most of working	16b. KIND OF BUSI	NESS/INDUSTRY	WIIIC
	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +		itation couns	el govern	ment	
YLAND by the hospit be detached at once.	CO	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Malden S	urname)	
	BE	Edward David Lux 190. INFORMANT'S NAME (Type/Print)	19b. MAILING ADI	SUS an			KS
	5	John W. Gurzick, J	r. 1851	Millstream I	0		021702
FORE e 6 may ector, pa		20a. METHOD OF DISPOSITION 1	20b. PLACE AND DATE OF DI cemetery, crematory or other p		DATE 20c. LOC	ATION — City or Ton	vn, Stata
BALTIMORE, er death. Page 6 may be the funeral director, page val.		21. SIGNATURE OF PUMERA SERVIDE LICENSEE)	22. NAME AND ADDRESS OF FAC	Stauf	Fer Fu	menal Home
BAL after deat by the fun noval. cal exan		Frank +	Julies	1621 Opes		PR. F	Ed. MD 2170
E P		23. PART I. Enter the diseeses, or complications that shock, of heart fellure. List only one ceu	caused the dean. Do not do	enter the mode of dying, such	as cardiec or respire	atory arrest,	Approximate Interval Between
the the		IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	caudiopul	10001001111 (Y sylver		30 WIN.
	_ 1			monary a			31
× 5 5 5	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	(OR AS A CONSEQUENCE OF):	lunousary	cm60/1	5	2 nous
O. BO ertificate b ing physicia rgiene prior other tra	FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that letted as or the common of the c	OR AS A CONSEQUENCE OF):	ucatilis			Junis
G # 8 # 9	ERI	that initiated events resulting in death) LAST	1999		uvycy		2mos
the death the atten d Mental H injury, o	ICAL CI	PART II. Other significent conditions contributing to	death but not resulting in the		Pert I. 24s. WAS AN A		WERE AUTOPSY FINDINGS
n = 5 = -1	DIC				PERFORM 1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
w requires that been signed but, of Health a shows any	: MED	DID TOBACCO USE CONTRIBUTE TO CA	IISE OF DEATH VES	□ NO □ LINCERTAIN	/		1 TES ZENO
S - S	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	28. PLACE OF DEATH (C	Check only one)			
F VIT, SICIAN: Th certificate the State the State the or Item	PHYSI		EB/Outpatient 3 DOA 4	Nursing Home 5 Residence			
NG PHYSIC fer this ce sath with th marked,	BY Pt	1- Netural 5 Pending (Month, Do		M 1 YES 2 NO	28d. DESCRIBE HOW IN.	JUHY OCCURED	ĺ
TTENDI TOR: A affer de 28 is	9	3 Suicide Could not be 280. PLACE Of	F INJURY — At home, farm, street atc. (Specify)	t, tactory, office	281. LOCATION (Street and City or Town, State)	d Number or Rural Ro	oute Number,
e china	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of MEDICAL EXAMINER: On the basis of ax					and manner as stated.
TO THE HOSPITAL (TO THE FUNERAL DE FIGE WITHIN 72 h	BE	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUM	BER SQ 1	29d. DATE SIGNED	(Month, Day, Year)
	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS	lemore M		Hoy kius	81.60	3
		31. DATE FILED (Month, Day Year) 1994 32. REGISTRAL	RESIGNATURE RONALL		<u>.</u>		
			-10				

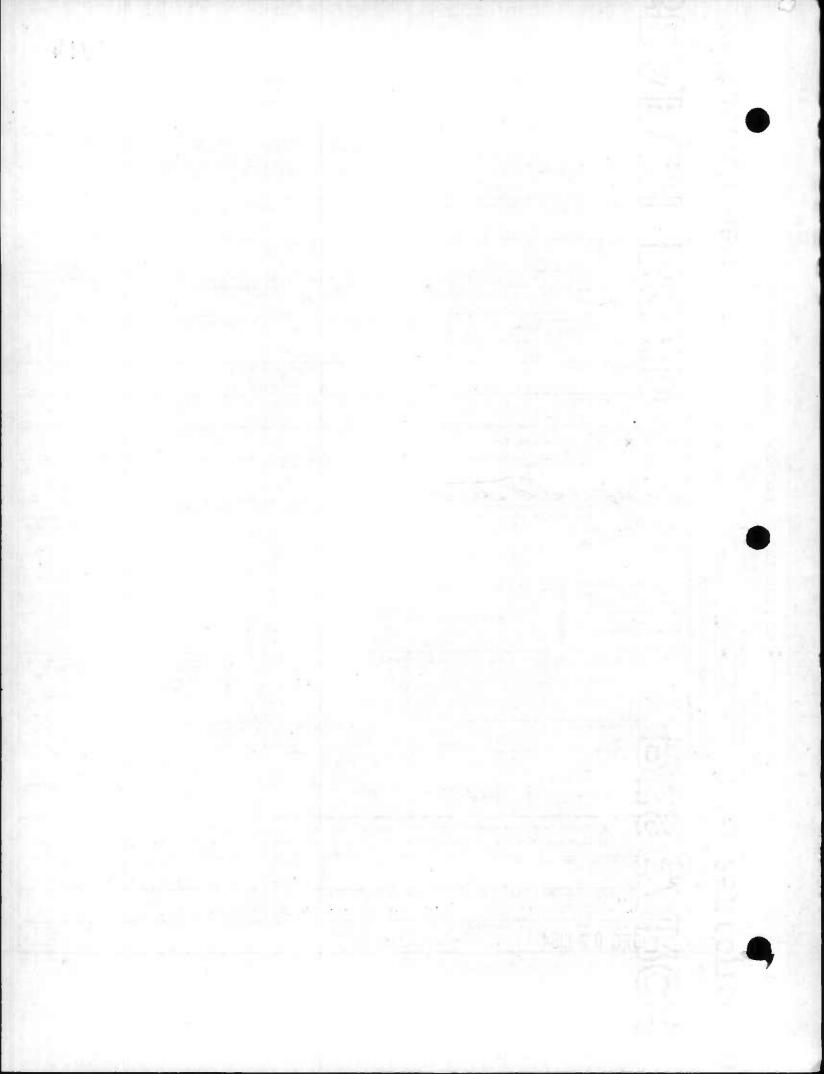


1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

		DICHARD	EDLIADD	ODI	EELEY	7		2. DAT	TH	DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	RICHARD 5. SEX	EDWARD 8. AGE (In yrs. Is	-			T		ember	5, 1		5:07
		1 M 2 F	B. AGE (IN YTS. IS	YRS.	IF UNDER	DAYS	HOURS MIN	(Moi	nth, Day, Your	7)	Coun	
	348-24-9385 9a. FACILITY NAME (If not institution, gla			1113.	at CITY	TOWN	OR LOCATION OF		29,	1933	IIII	inois
OB	217 Westvie	w Drive			90. CITY		rmont	DEATH			rede:	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COU	NTY		10c. CIT	Y, TOWN (OR LOCAT	TION					10d. INSIDE CITY
	Maryland	Freder	ick		Thu	rmor						1 XYES 2 N
FUNERAL	10e. STREET AND NUMBER					101	I. ZIP CODE					WHAT COUNTRY?
빌	217 West	12. WAS DECEDER		BMED	1 40	WM 0 DEC	21788 CENDENT OF HIS					d States
BY FL	1 Never Married 2 Married 3 Widowed 4 Optionroad	FORCES?	YES 2 X	NO		If yes, sp	ecity Cuben, Men 2 NO Spi	icen, Puerto	Rican, atc.))		CE — American Indian ck, Whita, atc. city: White
G	15. DECEDENT'S E (Specify only highest gr	DUCATION		ECEDENT'S				10	Sb. KIND OF	BUSINESS/II	NDUSTRY	
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5	66	le. Do NOT us	work done se retired.)	during mo	ost of working					
MP	9 +		С	omput	er p	rogi	ramer		techn	ology	/comp	puter
COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S	NAME (First	, Middle, Mai	den Surname)		
BE		aul Gre	eley				Marg				1ynn	
2	19a. INFORMANT'S NAME (Type/Print)		1				and Number or Ru					
	Kelly J. Whit	te			-	_	v Dr./tl		_		1788	
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 R	amoval from Stata	cemetery, cr	AND DATE	ther plece))		1		LOCATION -		
	4 ☐ Donation 5 ☐ Other (Specify)	LICENSEE	_ Hage	rstow	n Cr	emat	tory	12	/8 H	agers	town	,Marylan
	III SIGNATURE OF FUNERAL SERVICE	LIVERSEE		\			ND ADDRESS OF					al Home
	Carmon	2 ol	eren)			Main :					21788
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. // =	use on each lin	ie.			ode of dying, a	uch aa ca	TOTAL OF THE			Interval Be
CATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. Are	use on each lin	EOUENCE O	100 Pi			uch aa ca	indice of te			Interval Be Onset end
ERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. H = Due to	O (OR AS A CONSI	EOUENCE O	F):			uch aa ca				Interval Be Onset end
DICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. Due to b. Due to c. Due to	O (OR AS A CONSE	EOUENCE O	For Price Pr	./0			24e. WAS	S AN AUTOPS'S FORMED?		interval Be Onset end
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	a. Due to b. Due to c. Due to	O (OR AS A CONSE	EOUENCE O	For Price Pr	./0			24e. WAS	S AN AUTOPS		b. WERE AUTOPSY FINANILABLE PRIOR TO COMPLETION OF CO
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	a. Due for Due for d	O (OR AS A CONSE	EOUENCE O	For Price Pr	, / c	g cause given	În Part I.	24a. WAS PER 1 U YES	S AN AUTOPS		b. WERE AUTOPSY FIN AMILABLE PRIOR T COMPLETION OF CA
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other aignificent conditions are sufficient conditions.	DUE TO DUE TO d. HOSPITAL:	O (OR AS A CONSE	EOUENCE O	F): F): OTHE	nderlying	g cause given	In Part I.	24a. WAS PER 1 U YES	S AN AUTOPS		b. WERE AUTOPSY FINANILABLE PRIOR TO COMPLETION OF CO
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other algnificent conditions are supported in the support of the s	a. Due to b. Due to c. Due to d. Hospital: 1 Inpatient 2 280. DATE OI	O (OR AS A CONSE	EOUENCE OF TESTING	F): In the us OTHE 4 Numie OF	, / C	g cause given LACE OF DEATH 10 5 Deciden	In Part I.	24a. WAS PER 1 U YES	S AN AUTOPS	Y 24	b. WERE AUTOPSY FINANIABLE PRIOR TO COMPLETION OF COF DEATH?
PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other aignificent conditions in the cause of the	a. Due for Due for Due for d. Due	O (OR AS A CONSE	EOUENCE OF TESTING	F): F): OTHE	26. PI	g cause given	In Part I.	24a. WAS PER 1 U YES	S AN AUTOPS'S FORMED?	Y 24	b. WERE AUTOPSY FIN AMILABLE PRIOR T COMPLETION OF CA
TED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other aignificent conditions are sufficient conditions.	DUE TO DUE TO	O (OR AS A CONSE	EOUENCE OF COUNTY OF THE PROPERTY OF THE PROPE	OTHE 4 Number	26. PI	g cause given LACE OF DEATH 18 5 Decident JURY AT PRK7 YES 2 NO	In Part I. Check only 28d. D	24e. WASPER 1 VE:	S AN AUTOPS' FORMED? S 2 NO DW INJURY O	Y 244	b. WERE AUTOPSY FIR AMAILABLE PRIOR I COMPLETION OF COF DEATH?
ETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificent conditions are suiting in death Last 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Suicide 8 Could not detarmined.	DUE TO DUE TO	OF INJURY — At h, etc. (Specify)	EOUENCE OF COUNTY OF THE PROPERTY OF THE PROPE	OTHE	26. PIR: rsing Horrison, office time, dete	g cause given LACE OF DEATH THE 5 Decident JURY AT JU	in Part I. Check only as 6 Ott 28d. D 28l. LC Cit	24a. WASPER 1 UYES Ther (Specify) ESCRIBE HO DOCATION (Str. by or Rown, Si ause(a) and	S AN AUTOPS FORMED? S 2 NO OW INJURY O	Y 24	6. WERE AUTOPSY FIR AMALABLE PRIOR I COMPLETION OF COF DEATH? 1 YES 2 N
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificent conditions are suiting in death Last 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Suicide 8 Could not detarmined.	a. Due To b. Due To c. Due To d	OF INJURY — At h, etc. (Specify)	EOUENCE OF COUNTY OF THE PROPERTY OF THE PROPE	OTHE	26. PIR: rsing Horrison, office time, dete	g cause given LACE OF DEATH 1s 5 Decident JURY AT JUR	In Part I. Check only a 8 Ott 28d. D 28l. LC Rue to the c	24a. WASPER 1 UYES Ther (Specify) ESCRIBE HO DOCATION (Str. by or Rown, Si ause(a) and	S AN AUTOPS FORMED? S 2 NO OW INJURY Of tale) menner as si a, and due to	Y 24 CCURED per or flurel teled.	b. WERE AUTOPSY FIR AMALABLE PRIOR TICOMPLETION OF COOPDEATH? 1 YES 2 N
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other aignificent conditions in the cause of the	a. Due To b. Due To c. Due To d	OF INJURY — At h, etc. (Specify)	EOUENCE OF COUNTY OF THE PROPERTY OF THE PROPE	OTHE	26. PIR: rsing Horrison, office time, dete	g cause given LACE OF DEATH 18 5 Besiden 19 17 AT 19 18 2 NO 19 18 19 19 19 19 19 19 19 19 19 19 19 19 19	in Part I. Check only as 8 Ott 28d. D 28d. LC Che lue to the c the time, de	24a. WASPPER 1	S AN AUTOPS FORMED? S 2 NO OW INJURY Of tale) menner as si a, and due to	Y 24 CCURED per or flurel teled.	6. WERE AUTOPSY FIR AMALABLE PRIOR I COMPLETION OF COF DEATH? 1 YES 2 N
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other aignificent conditions in the cause of the	B. DUE TO b. DUE TO c. DUE TO d	USE ON each lin O (OR AS A CONSE O (OR AS A CO	EOUENCE OF COUNC	F): Z /) F): In the us OTHE 4 Nur BE OF JURY M street, fec	26. PIR: rsing Horrison, office time, dete	g cause given LACE OF DEATH 1s 5 Decident JURY AT JUR	in Part I. Check only as 8 Ott 28d. D 28d. LC Che lue to the c the time, de	24a. WAS PER 1 UYES 1 U	S AN AUTOPS FORMED? S 2 NO OW INJURY Of tale) menner as si a, and due to	Y 24 CCURED per or flurel teled.	1 VES 2 N
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificent conditions in the cause of the	B. DUE TO b. DUE TO c. DUE TO d	USE ON each lin O (OR AS A CONSE O (OR AS A CO	EOUENCE OF COUNTY OF THE PROPERTY OF THE PROPE	F): Z /) F): In the unit of line in the unit	26. PIR: rsing Horrison, office time, dete	g cause given LACE OF DEATH 18 5 Decident JURY AT JUR	In Part I. Check only a 8 Ott 28d. D 28d. LC Cit	24e. WAS PER 1 YES PER 1 Y	S AN AUTOPS FORMED? S 2 NO NOW INJURY O Det and Numberel a, and due to 29d, DV	Y 24 CCURED Der or Rural tated. The cause	b. WERE AUTOPSY FIN AMALABLE PRIOR T COMPLETION OF CA OF DEATH? 1 YES 2 N



BALTIMORE, MARYLAND 21215-00	AL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending p
BA	nours after de
	3
X 68760,	e executed within
BO	sate b
0	certifi
0	Jeath
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	requires that the
AL	e law
OF VIT	PHYSICIAN: Th
DIVISION	DR ATTENDING
_	7

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

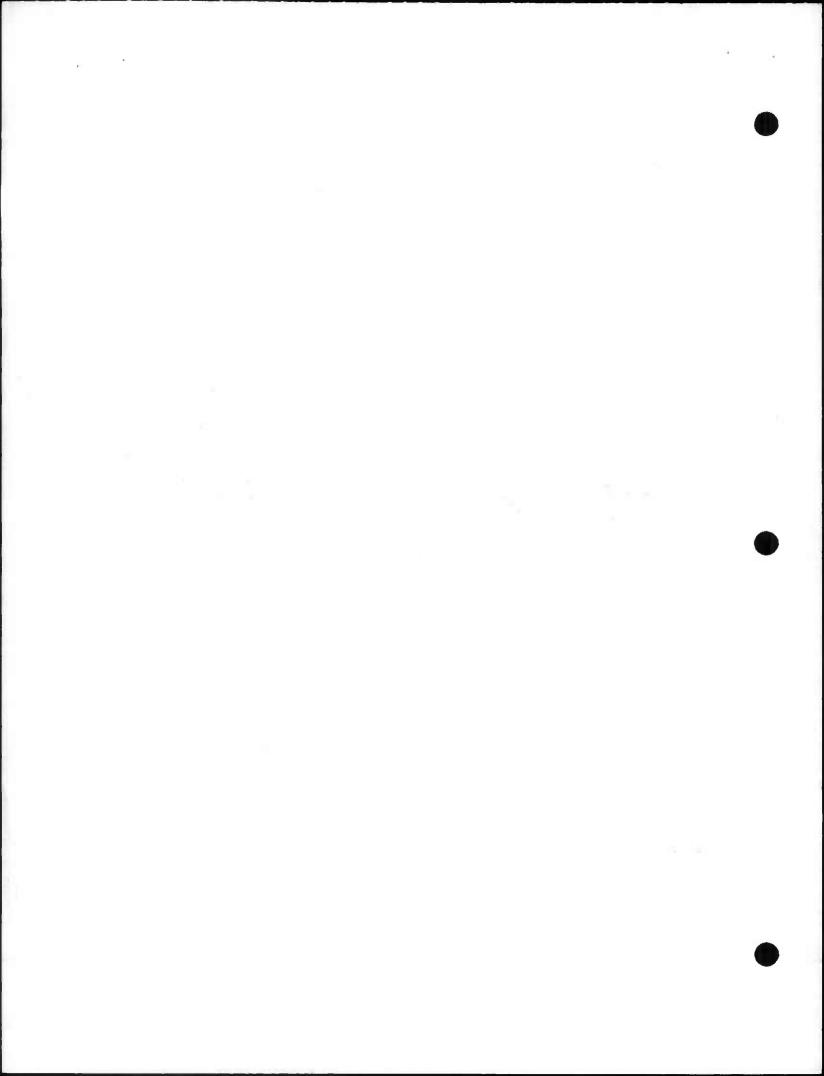
	i. DECEDENT'S NAME (First, Middle, Last) George	200	Gro	oss				2. DATE OF MONTH	DEATH DA		YEAR	3. TIME OF DEATH 12:50
0	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthda)					AR IF UNDE	7. DATE OF BIRTH 8. BIRTHPLA			LACE (State or Fore		
	218-14-3282 XXM 2□F 76 YR				THE DAY	YS HOURS	MIN.	Aug.	10. 1	918	Man Man	ryland
18	na. FACILITY NAME (If not institution, give	street and number)		9b.	CITY, TOV	WN OR LOCAT	ION OF DE				NTY OF DE	2
E I	55 Arthur King 1	Road			Prin	ce Fre	ederi	ck		Ca	lvert	
_	RESIDENCE OF DECEDENT											
CC II	Maryland Ca	alvert		10c. CITY, TO			1					10d. INSIDE CITY LIMITS?
	IO. STREET AND NUMBER	arvert		FI	Tuce	Frede						1 YES 2 N
< 1	55 Arthur King	Rđ				206				10g. C11	USA	TAI COUNTRY?
FUNER	II. MARITAL STATUS		T EVER IN U.S. ARME	ED.	13 WAS	DECENDENT		IIC OBIGINS	Spacify Yes	or No		- American Indian
B 3	Never Married 2 Married Married 2 Married Divorced	FORCES? 1 IF YES, GIVE W	YES 2 NO		If yes	, specify Cub YES 2 NO	en, Mexice	n, Puerlo Ric			Black,	Black
	15. DECEDENT'S EDI (Specify only highest grad	UCATION le completed)		DENT'S USU		PATION g most of work	ina	16b. K	NO OF BUS	INESS/INC	DUSTRY	
画上	Elementary/Secondary (0-12)	College (1-4 or 5 +	We D	o NOT use ret	tired.)	y most or work	"")					
COMPL	6			Farme	r							
8 1	17. FATHER'S NAME (First, Middle, Last)	7						ME (First, Mid				
H -		Gross		A The same			Annie			Heig		
0 '	Do homba Danse					eet and Numbe						00670
	Roberta Parran		20b. PLACE AN		_	ng Rd.	Pr	Ince	_		City or Tow	
	23. PART IVEnter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	t caused the dast se on asch line.	Re		mode of dy	oul	h as cardla	c or respi	ratory sn	rest,	Approximatintarval Be Onset and
Ē III	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING							т				
(3)		CAUSE (Disease or injury that initiated events resulting in death) LAST										
ERTIFIC	CAUSE (Disease or injury that initiated events	DUE TO										
MEDICAL CERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition Chronic Chronic	one contributing to		sulting in the	he under	lying causa	1	Part I. 2	La. WAS AN PERFOR	MED?		WERE AUTOPSY FINI MANLABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 JAME
MEDICAL CERTIFI	PART II. Other algnificant condition Characteristics PART II. Other algnificant condition Characteristics PART III. Other algnificant condition PART III. Othe	one contributing to	death but not res five (O		lying causa	de	ero,	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH?
SICIAN: MEDICAL CERTIFI	PART II. Other algnificant condition PART II. Other algnificant condi	d	death but not res five f	DOA 4 (2 THER:	6. PLACE OF	de.	eck only one) 6 Other (PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH?
PHYSICIAN: MEDICAL CERTIFI	PART II. Other algnificant condition PART II. Other algnificant condi	HOSPITAL: 1 Inpetent 2 28a. DATE OF (Month, D	death but not res Chive II ER/Outpetient 3 INJURY BY, Year)	DOA 4 C	2 FHER: Nursing F 28c	6. PLACE OF Home 6 GHP INJURY AT WORK? YES 2	DEATH (Ch	eck of fly one) 8 □ Other (3 28d. DESCI	PERFOR	MED?	CURED	AMALABLE PRIOR TI COMPLETION OF CA OF DEATH? 1 YES 2 AM
TED BY PHYSICIAN: MEDICAL CERTIFI	PART II. Other algnificant condition PART III. Other algnificant condition PART II. Other algnificant cond	HOSPITAL: 1 Inputent 2 28a. PLACE O	death but not reach to	DOA 4 C	2 FHER: Nursing F 28c	6. PLACE OF Home 6 GHP INJURY AT WORK? YES 2	DEATH (Ch	8 Other (1	PERFOR	MED?		AMALABLE PRIOR TI COMPLETION OF CA OF DEATH? 1 YES 2 AM
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O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	PART H. Other algnificant condition PART H. Other Algnificant condition PART H. Oth	HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, D) 28a. PLACE O building, SICIAN: To the best of at	death but not res Ave f ER/Outpatient 3 ER/Outpatient 3 INJURY ey, Year) F INJURY — At home etc. (Specify) my knowledge, deat xamination and/or in	DOA 4 228b. TIME OF INJURY e, farm, stree	2 28c M 1 1 rt, factory,	B. PLACE OF Home 6 P-P INJURY AT WORK? YES 2 office data and place on, dasth occur.	DEATH (Chocate of the control of the	ackronly one) 6 Other (i) 28d. DESCI 26f. LOCAT City or to the cause time, data ar	PERFOR YES 2 Specify) MBE HOW II ON (Street a Town, State) (a) and many ad placa, an	NJURY OC	or or Burel Ro	AMALABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 AMO
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	PART II. Other algnificant condition PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Cond not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	HOSPITAL: 1 Inpetient 2 28a. PLACE 0 building, SICIAN: To the best of a: ER	death but not res Ave f ER/Outpatient 3 ER/Outpatient 3 INJURY ey, Year) F INJURY — At home etc. (Specify) my knowledge, deat xamination and/or in	ODA 4 226b. TIME OF INJURY e, farm, stree h occurred st readgation, ir	2 28c M 1 1 rt, factory,	Home 6 Home 6 Home 6 Home 6 Home 6 Home 6 Home 6 Home 6 Home 1 Ho	DEATH (C) esidence NO o, and dua	act only one) 6 Other (1) 28d. DESCI 28f. LOCAT City or to the cause time, data at	PERFOR PERFOR ON (Street a flown, State)	NJURY OC	r or Rural Ro	AMALABLE PRIOR TICOMPLETION OF CA OF DEATH? 1 YES 2 AM Oute Number, and manner as sta (Month, Day, Year)

215-0020	
21	
MARYLAND	
BALTIMORE ,	
68760	
XO	

DIVISION OF VITAL RECORDS, P.O. BC

TO THE HOSPTAL DA ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dear of Health and Mental Hydiens prior to burial cremation or removal.
mark

	FOR 1 - STATE REGISTRAR	STATE OF MARYI	LAND / DEP/ CERTI	ARTMENT	OF HEALTH AND OF DEATH	MENTAL	HYGIENI REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O				TIME OF DEATH
- 8	Percy Allen Gr	iffith				Dec	1994		EAR {	3:21a M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	YEAR IF UNDER 24 HRS.	7. DATE OF	BIRTH Day, Year)	6.	BIRTHPLA Country)	CE (State or Foreign		
	221-09-9648		30 YRS	MONTHS	DAYS HOURS MIN.	Oct 1	9 191		Mary	land
	9e. FACILITY NAME (If not institution, give				TOWN OR LOCATION OF D			9c. COUNTY	OF DEATH	н
Ď.	Harford Memorial	Hospital		Havi	e de Grace			Harf	ord	
12	10a. STATE 10b. COUNT			CITY, TOWN OF					100	I. INSIDE CITY
ā	MD Cec	11	R:	ising :	sun				1 [YES 2 NO
FUNERAL DIRECTOR	71 Meadow Valle	y Dr			21911			USA	OF WHAT	COUNTRY?
ВҰ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 XNO	H	AS DECENDENT OF HISPA yee, specify Cuben, Mexic YES 2 NO Speci	en, Puerlo Ric			RACE — : Black, Wi Specify: hite	Americen Indien, hite, etc.
요	15. DECEDENT'S EDU (Specify only highest grad	JCATION le completed)	16a. DECEDENT		CUPATION wing most of working	16b. K	IND OF BUS	INESS/INDUS	TRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	T use retired.)	and those of working					
COMPLETED	12	0	Engine	eer			Rail			
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N			Surneme)		
BE	Harry Griffith 190. INFORMANT'S NAME (Type/Print)		10h MAIL	NG ADDRESS	Street and Number or Rural	e Medi		State Tip Co	-1-1	
2	Evelyn May Griff	ith			7alley Dr R					
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	noval from Stafe Cel	b.PLACE AND DAT metary, crematory of	reofdisposin or other place) W. Ceme	tery Dec 4	1994	20c. LOC	ing Su		21911
	21. SIGNATURE OF FUNERAL SERVICE LI			22. N	AME AND ADDRESS OF FA	ACILITY		21.6		21711
	1	1/_			T Foard Fur			um MD	2101	1
	23. PART I. Enter the diseeses, or	complications that couse	ed the death. De	D not antar t	1 S Queen S	ch se cardis	LIIG S	atory arrest	2191	Approximata
	ahock, or heart failura. IMMEDIATE CAUSE (Final	List only one cause on a	aech iine.				our Min			Intervel Between Onset and Death
	disease or condition resulting in dasth)	B. DUE TOYOR AS	A CONSEQUENCE	7 OFI:	n Forebi	DN				2 hrs
N	- BS-CVD-									
CERTIFICATION	Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING	DUÉ TO (OR AS	A CONSEQUENCE	OF):						0
IFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE	OF):						
ERT	resulting in death) LAST	d								
	PART II. Other significent condition	ns contributing to death	but not resultin	o in the und	eriving ceuse given in	Pert I. 2	4n. WAS AN	MITOPSV	24b WEI	RE AUTOPSY FINDINGS
CAL					,		PERFORI	WED?	AVA	ILABLE PRIOR TO MPLETION OF CAUSE
MEDIC						_ '	YES 2	□ NO	OF	DEATH?
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH	YES N	O UNCERTAI	ΝП			, ,	YES 2 NO
YA.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF D							
Sic	1 YES 2 NO	HOSPITAL: t Inpetient 2 ER/Out	patient 3 DOA	OTHER:	ng Home 6 - Residence	6 Other (Specify)			
Y PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		TIME OF INJURY	6c. INJURY AT WORK?	26d. DESC	RIBE HOW IN	JURY OCCUR	ED	
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferri	n, street, lecto	y, office		ION (Street er Town, State)	nd Number or I	Rural Route	Number,
PLET	290. CERTIFIER (Check only 1) CERTIFYING PHYS	SICIAN: To the best of my know	wledge, death occi	urred at the tin	e, date end piece, end du	e to the ceuse	(s) end men	ner es atated.		
COMPLET		ER: On the basis of examination							euse(s) end	s menner ee stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIE	don M	0)		29c. LICENSE NU	MBER 5		29d. DATE SI	GNED (Mo	nth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	EATH (HEM 27) (7)	rpe, Print)	\					(
	Me, lax	or MD	Kisi	na S	m., M8.	219	11			
	DEC 0 5 '94	32. REGISTRAR'S SIGN	MATURE Andale	2						
		0				-				DHMH-16 Rev 1/89



ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the footh recognition of the hospital or attending physician.	0 THF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTER	TO THE FUNERAL DIRECTOR	be filed within 72 hours after	MPORTANT: if item 28	

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC			MENTAL HYGIEN	E				
	1. DECEOENT'S NAME (First, Middle, Last))				2. DATE OF OEATH		3. TIME OF DEATN			
	4. SOCIAL SECURITY NUMBER		GREENE		NOVEMBER		1994 4 23A M				
	4. SOCIAL SECURITY NÜMBER 1		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 7 192	, 18	B. BIRTHPLACE (State or Foreign Country) MARYLAND			
	9a. FACILITY NAME (If not institution, give			DE CITY TOWN O	R LOCATION OF DE		9c, COUNTY OF DEATH				
H	PRINCE GEORGE HO	,	[]	CHEVE		AIN		CE GEORGE			
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT						1				
DIRECTOR		NNE ARUNDEL 10c. CITY, TOWN OR LOCATION ANNE ARUNDEL ANNAPOLIS					10d. INSI				
	10e. STREET AND NUMBER	1211011022	11111		ZIP CODE		1 TYPES 2 NO				
FUNERAL	14 JOHNSON PLAC	E			USA						
P.C.	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yas	or No- 1	4. RACE — American Indian, Black, White, atc.			
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D	ATES TAN		2XXNO Specify		Specify:				
	15. DECEOENT'S EDI (Specify only highest grad		18a. OECEDENT'S U			16b. KIND OF BUS	SINESS/INDUS	BLACK			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	rk done during mo retired.)	st of working						
MP	3rd 17. FATNER'S NAME (First, Middle, Last)		MAID			SOME ON		HOME			
	JAMES GREEN					ME (First, Middle, Malden ARRIE BROW)					
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	OORESS (Street a		Route Number, City or Tow.		iode)			
2	BENJAMIN DORSEY					ESVILLE, M					
	20a. METHOD OF DISPOSITION XX Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Complete Victorial C										
	4 Donation 5 Other (Specify)		DPE UM CHU	_	D ADDRESS OF FAC		EWATER	, MD.			
		1. Lee	20	REESE	& SONS N	MORTUARY.	P.A.				
	23. PART i. Enter the diseases, or					ANNAPOLIŚ,					
	shock, or haart failure.	. List only one causa on a	ach iina.					interval Between			
	immediate Cause (Fine) disease or condition realiting in death) Die to (OR AS K CONSEQUENCE OF): Onset and Death Onset and Death Onset and Death										
	DE TO (OR AS CONSEQUENCE OF):										
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
CATI	if sny, leading to immediate couse. Enter UNDERLYING										
Ē	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST	d									
AL C	PART il. Other significant conditio	ns contributing to death b	ut not reaulting in	tha underlying	cause given in	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
						1 YES 2		COMPLETION OF CAUSE OF DEATH?			
ME	717 707 1000 1107 007 1107							1 TES 2 NO			
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES 26. PLACE OF DEATN		UNCERTAIN	V 🗆 📗					
PHYSICIAN: MEDIC	EXAMINER?	HOSPIAL:		THER:	5 🗆 Residence	6 Other (Specify)					
표	27. MANNER OF OEATH	28e. DATE OF INJURY	28b. TIME	OF 28c. INJ	JRY AT	PERSONAL TOTAL	NURY OCCU	RED			
BY	1 Netural 5 Pending 2 Accident Investigation	Maleubs 117	94 10	M 1 🗆 Y	ES 2 NO	crossing	hith	y a vehelle			
	3 Suicide 8 Could not be 4 Nomicide datermined	28a. PLACE OF BUILD building, all building.	At home, farm, str	et, factory, office	Puso	281. LOCATION Vistreet a	and Number of	Rural Route Number,			
Ē	29a. CERTIFIER	Caru I Jes	10 mil	c.run	rivara,	Annapo	us, A	Hrundes, Mo			
COMPLETED	(Check only	SICIAN: To the best of my knowl IER: On the basis of examination					ner as stated	· ·			
	296. SIGNATURE AND TITLE OF CERTIFIE	9	. 1		P24c. LICENSE NUM	IBER	_	SIGNED (Month, Day, Year)			
) BE	Jugarto Y. Ko	duful WI		4	12/20	30	Wer	6-26,19911			
2	30 HAME INO ADDRESS OF REASON WI	HO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, P	rint)	11	a c	21. 1				
1	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	1,5009/	Koyba	umct.	is. M.	mo	20748			
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permit. use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for 最 an and completely filled in by to burial, cremation, or remon the attending physician and Mental Hygiene prior to buri signed by the certificate has been in the State Dept. of I with t DIRECTOR: After the hours after death was OR

BALTIMORE, MARYLAND 21215-0020

must examiner medical the traumatic event, 0 shows any Item 23 5 is marked, 28 FUNERAL within 72 h HOSPITAL Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

Amended # 9a STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR JEANNE Н. GLASER 94 NOV 1:40 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) DAYS HOURS 1 M 2 F YRS. 489-28-6266 71 July 27,1923 Missouri 880 QUINCE ORCHARD BLVD, #102 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GAITHERSBURG MONTGOMERY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 880 Quince Orchard Blvd., #102 20878 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or It yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 YES 2 NO Specify: 3√√ Widowed 4 ☐ Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 5+ Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Alva Leon Holt BE Mildred Buckingham 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John C. Glaser 9550 Ella Lee Lane, #1440, Houston, Texaws 77063 20a, METHOD OF DISPOSITION

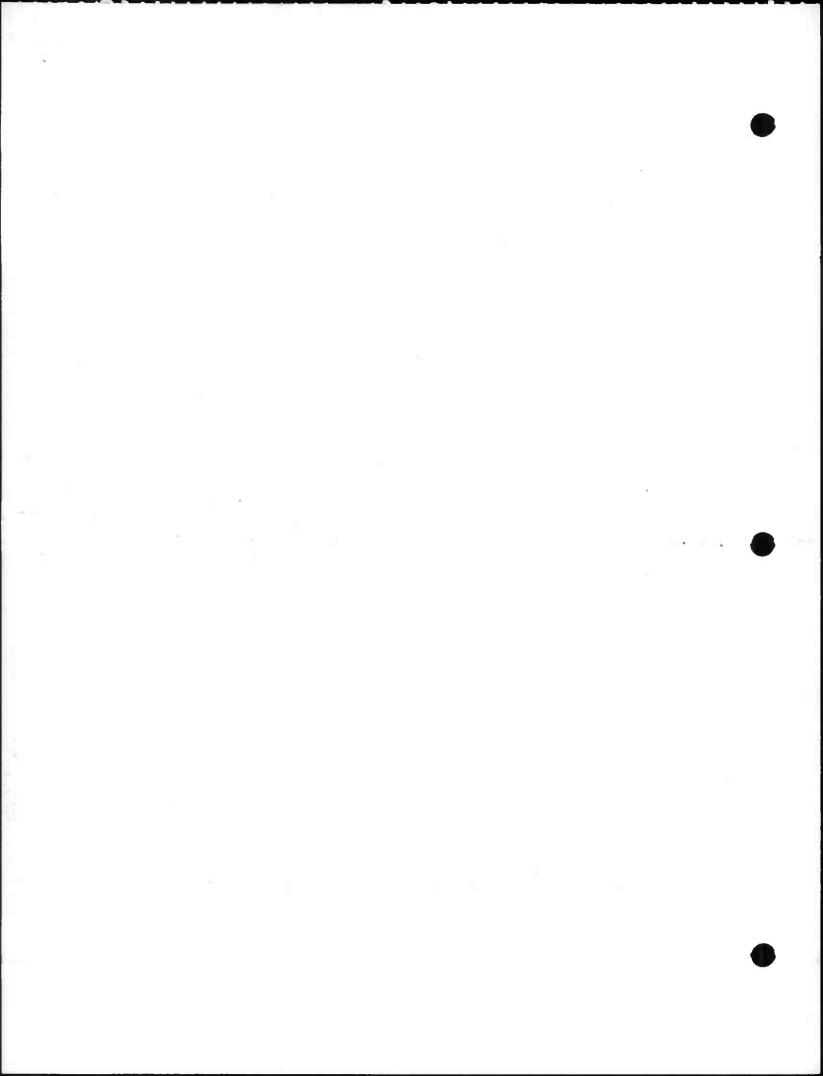
↑X Burlal 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 12/1/94DATE Arlington National Cemetery 4 Donation 5 Other (Specify) Arlington, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral M00348 Home/Rockville, Inc., 300 W. M. Rockville, Maryland 20850-280

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Inc., 300 W. Moland 20850-2805 300 W. Montgomery Ave Approximate shock, or heart failure. List only one cause on each line Interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition CONGESTIVE HODING +AILLIRE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSPOUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? **AVAILABLE PRIOR TO** COMPLETION OF CAUSE 1 YES 2 NO 1 X YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER: TX NES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Nome 5X Residence 6 ☐ Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 26d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 Natural 1 YES 2 NO В 2 Accident Investigation 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(a) end manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and pieca, and due to the cause(a) and manner as stated. 290. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE NOV 26,1994 O.C.M.E. 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) . ICOR MM 111 Penn Street, Baltimore, Maryland 21201 32 REGISTRAN'S SIGNATURE Gruna Davidson-Randale 7994

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending by the a	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, or empraise must be notified at once.	
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	FOR STATE REGISTRAR	STATE OF N	MARYLAND /				EALTH AND	MEN'	TAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last,	2. D.							ATE OF DEATH			3. TIME OF DEATN	
	Bernard Fr	ancis Gallagher							November 23, 1994 11:2				
j,	4. SOCIAL SECURITY NUMBER	5. SEX		E (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH							. BIRTN	PLACE (State or Foreign	
	577-60-3255	1 😡 M 2 🗆 F	86	YRS.	MONTHS	DAYS	HOURS MIN.	Dec	ember 1		Country	nington,D.C.	
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN C	R LOCATION OF		0	9c. COUNT			
8	6905 40th Avenue				Uni	ver	sity Pa	rk		Prine	ce (George's	
DIRECTOR	6905 40th Avenue									1 2 211			
	300 100			10c. CIT	Y, TOWN O						1	10d. INSIDE CITY LIMITS?	
	Maryland Prince 100. STREET AND NUMBER	ce George	S		Univ		ity Par	k		1 TYES 2 NO			
FUNERAL						101						WHAT COUNTRY?	
빌	6905 40th Avenue	12. WAS DECEDEN	T EVER IN ILC. AD	WED.	1 40 11		20782				U.S.A.		
	1 Never Married 2 Married	FORCES? 1	YES 2 N	MED	11	yea, spe	cify Cuban, Maxi	can, Puar	IGIN? (Specify Year rto Rican, etc.)	or No—	Biack	— American Indian, c, White, etc.	
≱	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1	YES	2 X NO Spec	olfy:			Specia	†√: ite	
	15. DECEDENT'S ED	UCATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO)N		16b. KIND OF BUS	SINESS/INDU:		Ite	
H.	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5 +	(Gr	Do NOT u	work done di se retired.)	Acc	st of working Ount						
COMPLETED		5+					ost Ana	1yst	Fede	ral G	ove	rnment	
Ö	17. FATNER'S NAME (First, Middle, Last)				_		18. MOTHER'S	IAME (Fir	si, Middfe, Maiden	Sumame)			
BE (Bernard A. Galla	gher					Mary	Cath	nerine H	alble	ib		
0	19a. INFORMANT'S NAME (Type/Print)								lumber, City or Town				
-	Lucille R. Galla	gher						vers				and 20782	
	20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Rai	noval from Stata	20b. PLACE A cemetary, cres	matory or o	ther place)			1		CATION — CI	,		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	- Gate o	f He	aven	Cem	etery 1	1/26	5/94Silv	er Sp	rin	g.Maryland	
	21. SIGNATURE OF PUNERAL SERVICE L	CENSEE					S .T. CO		ns Funer	al Ho	me.	Tnc.	
	General	Code	a		500) IIn	iversit	v R1	vd. W	Sil S	nr	MD 20901	
	23. PART I. Eletar tha diseasee, or ehock, or heart fellura	Complications that	t coused the de	eth. Do r	not enter t	the mo	de of dying, au	ch aa c	erdiec or reepi	ratory erres	nt,	Approximate	
1	IMMEDIATE CAUSE (Final		1 .				,					Intarval Between Onsat and Daeth	
	disease or condition resulting in deeth)	0/	OR AS A CONSEC	2 arc	cinor	na	Lan	5				1 year	
S	Sequentielly list conditions,	b	on as Ponseo	m C	. 0	f (mg -					2 years	
HIFICATION	if any, leading to immediate cause. Enter UNDERLYING	502.10	(OII AS & CONSEC	OENCE O	·).								
유	CAUSE (Disease or Injury that Initiated events	c. DUE TO	(OR AS A CONSEC	UENCE O	F):							<u> </u>	
	resulting in deeth) LAST	4											
5	DART II ON THE STATE OF THE STA	***									_		
À.	PART ii. Other algnificent condition	ne contributing to	deeth but not re	euiting	in the unc	deriying	ceuse given i	n Part i.	. 24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă									1 YES 2	□ NO		OF DEATH?	
PHYSICIAN: MEDIC												YES 2 NO	
ž I	DID TOBACCO USE CONT	RIBUTE TO CA					UNCERTA	IN 🗵					
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		-						
2	1 YES 2 NO	1 Inpatient 2 I					5 Masidence						
	1 Netural 5 Pending	(Month, Da	ay, Year)	28b. TIM INJ	URY	28c. INJU	PRY AT RK? ES 2 NO	28d. (DEŞCRIBE HOW II	IJURY OCCU	RED		
ā	2 Accident Investigation 3 Suicide Could not be	28a, PLACE OI	F INJURY At hor	ne term i	ttreet facto			201	OCATION (Street a	nd Number or	Ound O	house Mountain	
3	4 Nomicide 8 Could not be	building,	etc. (Specify)	,,	street, ractor	, onice		201.0	City or Town, State)	rid Namber or	nurei n	oute Number,	
MPLEIEU	29a. CERTIFIER	NCIAN: To the head of			101 2		- 110						
Ē		SICIAN: To the best of										and manner as stated.	
3	296. SIGNATURE AND TITLE OF CERTIFIE				,, op				wa and praca, an				
	290. SIGNATORE AND TITLE OF CERTIFIE	OK.	. /				29c. LICENSE N		2 7	29d. DATE S	/	(Month, Pay, Year)	
2 ∦	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALIS	E OF DEATH (ITEM	27) /Turns	Print)		1)21			/	1/2	7/7/	
	M BERARR		780	BA	-1 TIM	har	LE tu	E 10	07 C1	DW	d	21740	
-	31. DATE FILED (Month, Day, Year)	32. REGISTRAI	R'S SIGNATURE	1271	-11	-01			. 01	1-7	4		
	NOV 3 n 199		Davidson-A	andel	2							1	
	U 100	0	1.1001					_				DHMH-16 Rev 1/89	



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CORDS, P.O. BOX 68760,	res that the death certificat

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATH MONTH DA	AY YEAR	3. TIME OF DEATH		
		Evelyn R. Gra			November 2	25, 1994	7:45 A M		
		6. AGE (In yrs. last	MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Count	IPLACE (State or Foreign		
	205-12-0584 1 9a. FACILITY NAME (If not institution, give stree	□ M 2 💢 F 88	YRS.	02.1	March 20, 1				
E.	Althea Woodland Nu			town or Location of DE	EATH	9c. COUNTY OF D			
CIC	RESIDENCE OF DECEDENT	TO ING				Montgom	ery		
DIRECTOR	Maryland Montgo		10c. CITY, TOWN O				10d. INSIDE CITY LIMITS?		
	Maryland Montgo	JilleTy	Silver	Spring 10f. ZIP CODE		10g. CITIZEN OF N	1 YES 2 XNO		
FUNERAL	9039 Sligo Creek Pa	arkwav. #601		20901		United			
NO.	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 X NO	ED 13. V	AS DECENDENT OF HISPAN	IC ORIGIN? (Specify Yea	or No- 14. RACI	E — American Indian, k. White, alc.		
ВУГ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		yes, specify Cuban, Maxica YES 2 NO Specify		Spec	fly:		
	15. DECEDENT'S EDUCAT	TON 18a. DEC	EOENT'S USUAL OC	CUPATION	16b, KIND OF BUS		white		
COMPLETED	(Specify only highest grade con Elamentary/Secondary (0-12)	mpleted) (Givi	e kind of work done do Do NOT use retired.)	uring most of working					
MPI		4 Te	eacher		Publi	c School	s		
	17. FATHER'S NAME (First, Middle, Last) John Marshall Ph	inne			ME (First, Middle, Maiden	*			
BE	19a, INFORMANT'S NAME (Type/Print)		MAILING ADDRESS	Lillis (Street and Number or Rural I					
2	Keith C. Gray			idge Court,			74006		
	20a. METHOD OF DISPOSITION 1	20b. PLACE AF	ND DATE OF DISPOSI	TION (Nama of		CATION — City or To			
	4 Donation 5 Other (Specify)	Subus	etory or other place)			er Sprin	g, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE O		app Funeral		РΔ			
	0007	ev. Mapy	9	33 Gist Ave	nue. Silve:	r Spring	, MD 20910		
	23. PART I. Enter the disease, or comenock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	t only one ceuse on each line.	reene	ena of co		ratory arreat,	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):								
AL (PART II. Other algnificant conditions of	ontributing to death but not re	aulting in the unc	derlying cause given in	Part i. 24a. WAS AN PERFOR		WERE AUTOPSY FINDINGS		
					1 PYES 2	7709	COMPLETION OF CAUSE OF DEATH?		
M	DID TORACCO LICE CONTINUE	NITE TO CAUGE OF DEAT	WEG 🗆 A				1 TYES 2 THO		
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		OF DEATH (Check o		<u>ч </u>				
SIC		IOSPITAL: □ Inpatient 2 □ ER/Outpatient 3 □	DOA 4 X Nurs	: ing Home 5 🗆 Residence	8 Other (Specify)				
Y PHYSICIAN: MEDIC	27. MANNER OF GEATH 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c, INJURY AT WORK?	28d. DESCRIBE HOW IN	NJURY OCCURED			
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At hom building, etc. (Specify)	e, ferm, streel, lecto	ry, office	281. LOCATION (Street a City or Town, State)	and Number or Rural F	Route Number,		
ia l	29a. CERTIFIER	N. T. M. Carrier and A. A. A.							
COMPLETED		N: To the best of my knowledge, dast On the bests of axamination and/or in					i) and menner as stated.		
H	29b. SIGNATURE AND TITLE OF CERTIFIER	My		29c. LICENSE NUN	BER PG	29d. DATE SIGNED	(Month, Day, Year) Der 25, 1994		
5	30. NAME AND ADDRESS OF PERSON WHO C Michael E. Leibow	OMPLETEO CAUSE OF OEATH (ITEM	27) (Type, Print) # 120 New	305 Hampshire Av	venue Silv		ng, MD 20904		
	31. DATE FILED (Month, Day, Year) NOV 2 8 1994	32 REGISTRAR'S SIGNATURE Julia Davidson-Ron		, amportato A	. 51.55, 511	or obiti	191 110 20304		
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within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hurial-transit
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DIRECTOR

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

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5

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Print)

111

gandell

32. REGISTRAR'S SIGNATURE relia Savidson

LOCKES

1994

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2 year)

31, DATE FILED (MOR

notified at be must examiner removal medicai 0 the nation. other traumatic event, Слеп and com burial, c and attending physician are requires that the death certificate be 6 Mental injury, signed by t Health and 23 shows any certificate has been WE Dept. item ? State OR ATTENDING PHYSICIAN: the 6 with t marked, DIRECTOR: After the hours after death v 60 28 item TO THE HOSPITAL OF THE FUNERAL D be filed within 72 hc IMPORTANT: If it

68760

BOX (

P.0.

DIVISION OF VITAL RECORDS,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Mauricio GALTAN 2. DATE OF DEATH 3. TIME OF DEATH YEAR MAURICO NOV 94 4:20 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 XM 2 YRS. MAY 23,1958 219-17-4924 El Salvador 36 Se. FACILITY NAME (If not institution, give street and nur 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 - YES 2 X NO Maryland Montgomery Rockville 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14109 Arctic Avenue 20853 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexicen, Puerio Ricen, etc.)
1 XYES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 X Merried Specify: 3 Widowed 4 Divorced Salvadoran White 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Barber Tonsorial 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) Herminio Villalobos Caceres Graciela deJesus Gaitan 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Teresa Gaitan 14109 Arctic Avenue Rockville, Maryland 20853 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Burlel 2 Cremation 3 Kamoval from State General 4 Donetion 5 Other (Specify) El Salvador 11/30/94 Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil.Spr., MD 20901 23. FART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert fallure. List only one ceuee on each line. Interval Between hand Cutting Wounds **IMMEDIATE CAUSE (Final** Sho Onset and Death disesse or condition 70 W resulting in deeth) DUE TO (DR AS A CONSEQUENCE OF): Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY YES 2 NO DF DEATH? 1 YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 □ Inpatient X X ER/Outpatient 3 □ DOA **EXAMINER?** OTHER: 1X X ES 2 NO 5 Residence 8 Other (Specify) 280. DATE OF INJURY 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT 2 2 Day. 1 Natural 8 М Investigation 2 Accident PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and No 3 Suicide 8 Could not be 4 Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end menner ee stated. MEDICAL EXAMINER; On the ation and/or investigation, in my opinion, death occursd at the time, data end place, and due to the cause(s) and menner se stated, 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

O.C.M.E

Penn Street, Baltimore, Maryland 21201

NOV. 22,1994

Amended # 2, 18, 12/2/94, J.W., Montgomery 1- STATE STATE OF MARYLAND, DEPARTMENT County 36922

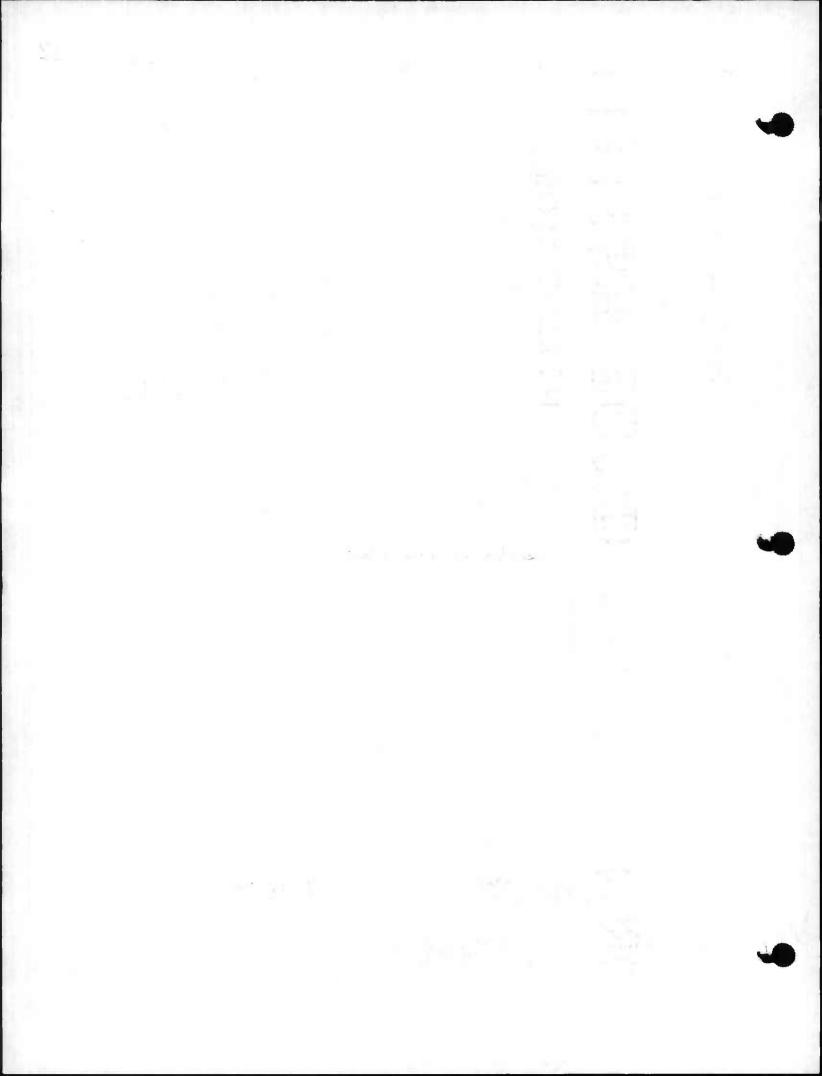
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO		
1. DECEDENT'S NAME (First, Middle, Last) NORMAN GRIFF				: N	OVEMBER	"-19 "-20, 1	3. TIME OF OEATH
4. SOCIAL SECURITY NUMBER 578 12 2605			UNDER 1 YEAR	IF UNDER 24 HRS.	DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country) Washington,
90. FACILITY NAME (If not institution, give 1009 CHILLUM F			YATTS	VILLE	Н	9c. COUNTY	OF GEORGES
10a STATE 10b. COUN PRIN	CE GEORGES		TSVII				10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{NO} \) NO
100. STREET AND NUMBER 1009 CHILLUM F	D. #309		101	20782		U.S.	N OF WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	If yes, sp	ENDENT OF HISPANIC selfy Cuban, Mexican, ZX NO Specify:		n or No— 14	RACE — American Indian, Black, While, etc. Specific HITE
15. OECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	18a. OECEDENT'S US (Give kind of work life. Do NOT use n	k done during ma etired.)	st of working	16b. KIND OF BU		
12 17. FATHER'S NAME (First, Middle, Last) RICHARD	RIFFIS	PAINTER	/ MAIN.	TENANCE 18. MOTHER'S NAMI Eliza	(First, Middle, Melden	Surname)	Pearson
19a. INFORMANT'S NAME (Type/Print)	KILLIA	19b. MAILING AD	DRESS (Street a	ETTZO		n, State, Zip Co	
ANNA GRIFFIS			AS 10				
20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 Re 4 Donation 5 Other (Specify)	moval from State	bb. PLACE AND DATE Of Commeters, Cremeters or TINCO	LN CEN	METERY N	ov. 23,		y or Town, Stata BRENTWOOD
21. SIGNATURE OF FUNERAL SERVICE I	JOHNSEE BY	w	TAKON	AD ADORESS OF FACI NA FUNER WASHING	AL HOME	•	CARROLL ST
disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bDUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF):	ident	-			
thet initiated events resulting in death) LAST	d	A GONGEOGENGE OF J.					
PART II. Other algorificent condition	one contributing to death	but not resulting in	the underlyin	g cause given in P		RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Chec	k only one)		
EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou		OTHER:	ne 5 ⊡⊈Raaldenca 8	Other (Specify)		
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		RY W	JURY AT ORK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCU	RED
3 Suicide 6 Could not b	28e. PLACE OF INJUR building, etc. (Sp	RY — Al home, farm, streedily)	eet, factory, offic	ca .	281. LOCATION (Street City or Town, State		r Rural Route Number,
CONSUM UNITY	'SICIAN: To the best of my kno NER: On the basis of axaminat						f. cause(s) and manner as stated.
296. SIGNATURE AND TITLE OF CERTIF	1-snop			D = 178			DV. 21,1994
30. NAME AND ADDRESS OF PERSON OF					-		
31. DATE FILED (Month, Day, Year)	. 3717 38th	AVE., E	BRENTW	OOD, MD	•		
NOV 2 1 19	34 Julia Davi	Son-Randell					

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within clears after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely limited in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,



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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a fire feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

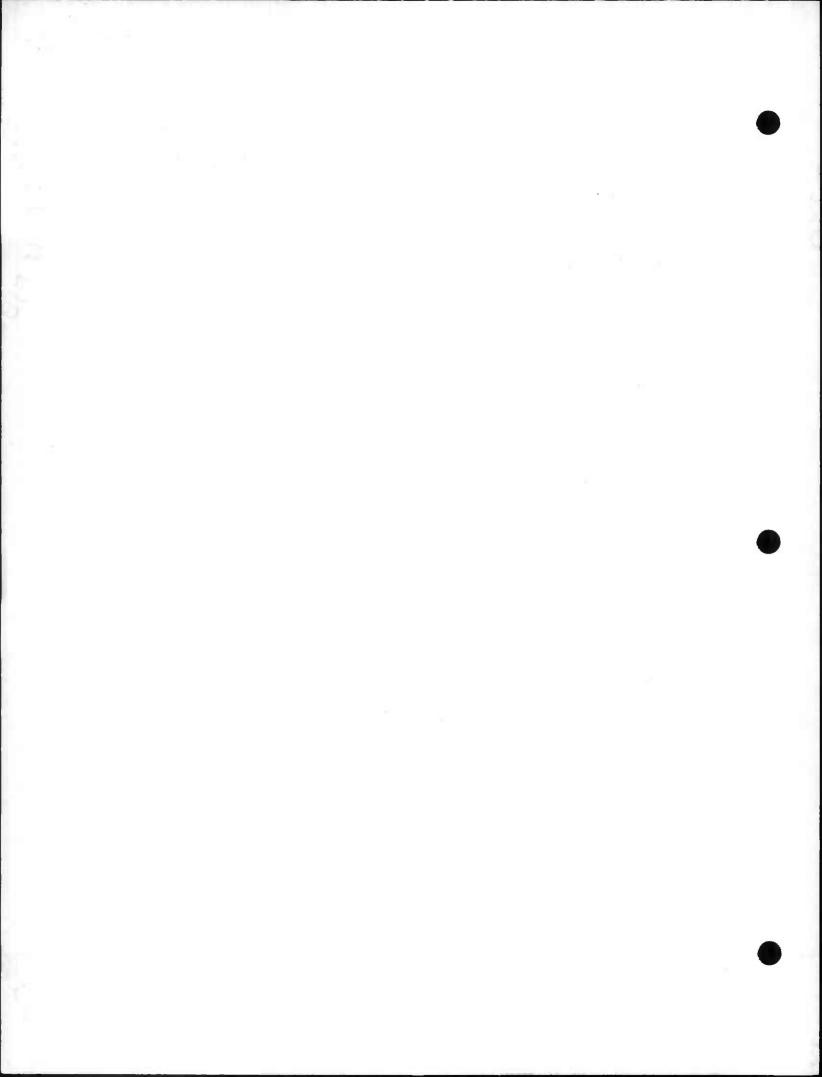
FOR STATE

	REGISTRAR		CI	ERTIFIC	CATE OF	DEATH		REG. NO				
	1. DECEOENT'S NAME (First, Middle, Last)						2. DATE	OF DEATN			3. TIME OF DI	EATH
- 1	Edith Johanna Ga	rdnor					MONT			YEAR		A
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las					mber 2	0,19		6:00	A M
			MGE (In yrs. las		ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		OF BIRTN		8. BIRTH	IPLACE (State or	Foreign
- 1	058-28-8060	1 M 2 X F 8	36	YRS.			Marc	h 24,1	908			
	9a. FACILITY NAME (If not inatitution, give at	reet and number)		9	b. CITY, TOWN	OR LOCATION OF				NTY OF D		
E	9727 Mt Piccah Po	and #1/.12			C + 1	Constant						
KI	9727 Mt. Pisgah Ro	Jau #1412			STIVEL	Spring			MOI	ntgo	mery	
DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE C	ITY
%	Maryland Mor	+			. 1						LIMITS?	
51	10e. STREET AND NUMBER	ntgomery		5.	ilver S						1 YES 2	
FUNERAL					10	f. ZIP CODE			10g. CITI	ZEN OF V	WHAT COUNTRY	7
<u> </u>	9727 Mt. Pisgah Ro	oad #1412				2090	3			U.S	. A .	
5	11. MARITAL STATUS	12. WAS DECEDENT EVEN FORCES? 1 1	ER IN U.S. AR	MED	13. WAS DE	ENDENT OF NISP	ANIC ORIGIN	7 (Specify Yes	or No—	14. RACE	- American In	ndlan,
	1 Never Married 2 Married	IF YES, GIVE WAR O	R OATES	NO.	1 TYES	ecity Cuban, Maxi	can, Puerto I	Rican, atc.)		Speci	c, White, etc.	
BY	3 🔀 Widowed 4 🗌 Divorced								_	Whi		
	15. DECEDENT'S EDUC		16a. DE	CEDENT'S US	BUAL OCCUPATI	ON	16b	KIND OF BUS	SINESS/INC	USTRY		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G	ive kind of wor Do NOT use i	rk done during ma retired.)	ost of working						
7	Electrically (0-12)	2		NT				1. 1				
2				Nurse				edical				
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					18. MOTNER'S N	AME (First, A	Aiddle, Maiden	Sumame)			
BE	Charles	Johnson				Sus	anne		Ar	nders	son	
	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING A	DDRESS (Street	and Number or Run	Route Numb	per, City or Tow	n, State, Zip	Code)	2	20903
2	David J. Gardner		٩	727 Mi	r Pico	ah Road	#1/.1	2 641	0 ° C+	min	_	
	20a. METHOD OF DISPOSITION				DISPOSITION (N		1/141.		CATION -			and
	1 N Burlel 2 Cremetion 3 N Remo	oval from Stata						Hast	ings	on I	wn, State Hildson -	
- 1	4 Donation 5 Other (Specify)		Mount	Норе		ry 1		4	WBN_	York	ludson,	
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				S J. Co.		E	-1 II.		T	
	111. 1	200-0	01							-		
	23. PART I. Entar the diseases, or c	omplications that one	war	oth Do set	1300 0	niversi	EA RIA	vd., W.	Sil.	Spr		
	shock, or haart fellure. I	ist only one cause o	n aach lina		antar tha me	ide or dying, su	cn as card	liac or reapi	retory srr	est,	Approxi	mste Between
- 1	IMMEDIATE CAUSE (Final	A +	1	-								nd Death
	disease or condition resulting in death)	(N) PLEUN	or to	FUSS	Last							
- 1	, and the same of	DUE TO (OR	AS A CONSEC	DUENCE OF):					_		+	
-		CAPROM	- A	nde	5							-
CERTIFICATION	Sequantially list conditions,	DUE TO (OR /	AS A CONSEC	DUENCE OFI	· ·						-	/
¥	If sny, lasding to immediata cause. Entar UNDERLYING	ASUN									6/24/	03
유미	CAUSE (Disesse or injury	DUE TO (OR	AS A CONSEC	MENCE OF							11-11	7,-
Ē	that initiated events reaulting in daeth) LAST	1 -00-1	DL	L.							1.1.	162
E		Moret	T		>						4/024	172
	PART II. Other significant conditions	contributing to deal	th but not r	equition in	the underlyin	a course object t	Don't I			T	1//	
EDICAL		to duct	Dut Hot I	additing in	tha dilderlyin	g cause givan i	raiti.	24a, WAS AN PERFOR	MED?	240.	WERE AUTOPSY AVAILABLE PRK	OR TO
ă								1 YES 2	NO		COMPLETION O DF DEATH?	F CAUSE
ME.									/	- 1	1 YES 2	NO I
	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEA	TH YES	Пио	UNCERTA	IN \square					
₫	25. WAS CASE REFERRED TO MEDICAL		-		(Check only one)	- CITCLE CO		-				-
PHYSICIAN:	EXAMINER?	HOSPITAL:	0.4	C	THER:	V						
≚ I	27. MANNER OF DEATN	26a. DATE OF INJU			☐ Nursing Hon		_					
ᆲ	1 Netural 5 Pending	(Month, Day, Ye		26b. TIME (Y WC	URY AT	28d. DES	CRIBE HOW II	JURY OCC	URED		
à l	2 Accident Investigation				M 1 🗆	YES 2 NO						
	3 Suicide 8 Could not be	28a. PLACE OF INJ building, etc. (URY — Al hor Specify)	me, farm, stre	et, factory, offic			ATION (Street a	nd Number	or Rural R	loute Number,	
LL III	4 Nomicide determined	11 100000000000000000000000000000000000					Only (or rown, orane)				
F 1				_				-				
	29a. CERTIFIER	NAME TO A SECOND										
MPLET	(Check only	ZIAN: To the best of my k										
OMPLET	(Check only) and manner as	stated.
	(Check only						e time, data			e cause(s	-	
BE COMPLETED	(Check only one) 2 MEDICAL EXAMINER					eath occured at th	e time, data		d due to the	e cause(s	-	
	(Check only one) 2 MEDICAL EXAMINES	1: On the basis of examin	ation and/or i	nvestigation,	In my opinion, c	eath occured at th	e time, data		d due to the	e cause(s	-	
띪	(Check only one) 2 MEDICAL EXAMINES		ation and/or i	nvestigation,	In my opinion, c	eath occured at th	e time, data		d due to the	e cause(s	-	
띪	(Check only 1 CERTIFYING PNYSIC ONL) 2 MEDICAL EXAMINER 210 SIGNATURE AND NITTLE OF CERTIFIER 30 NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF	OEATH (ITER	nvestigation,	In my opinion, c	eath occured at th	e time, data		d due to the	e cause(s	-	
띪	(Check only one) 2 MEDICAL EXAMINES	COMPLETEO CAUSE OF 32. REGISTRAR'S S	OEATH (ITER	nvestigation,	In my opinion, c	eath occured at th	e time, data		d due to the	e cause(s	-	
띪	(Check only 1 CERTIFYING PNYSIC ONL) 2 MEDICAL EXAMINER 210 SIGNATURE AND NITTLE OF CERTIFIER 30 NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF	OEATH (ITER	nvestigation,	In my opinion, c	eath occured at th	e time, data		d due to the	e cause(s	-	

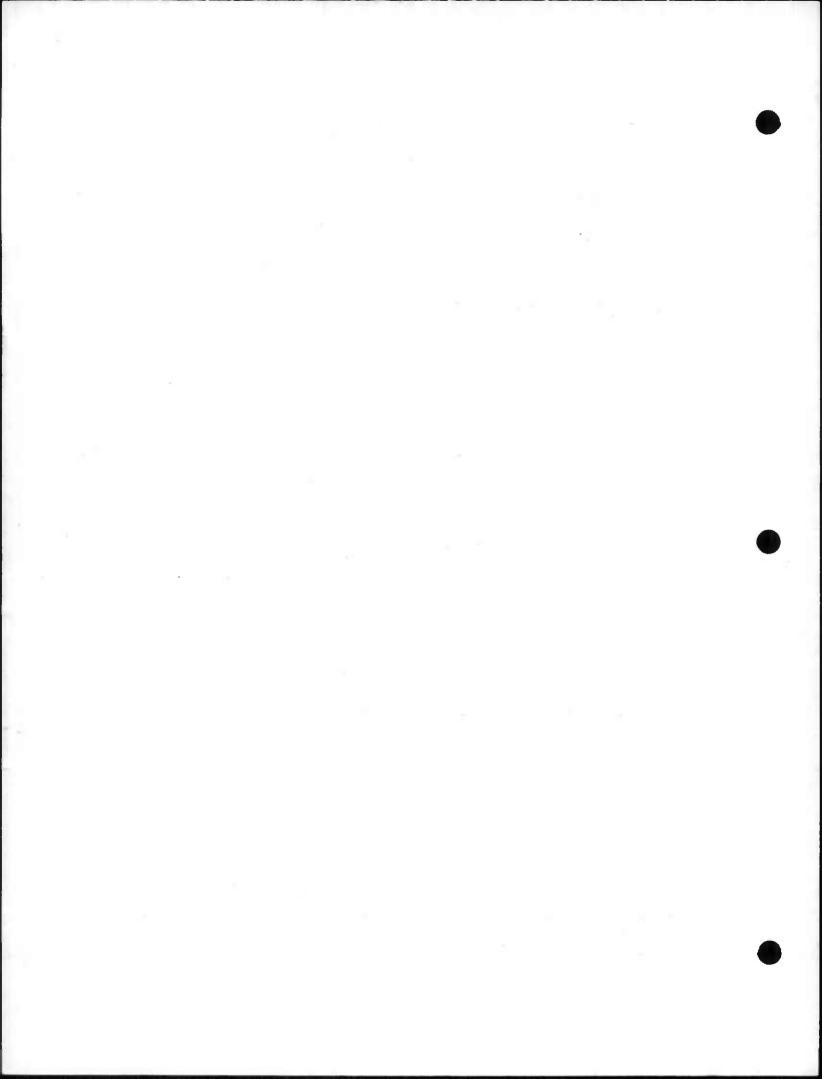
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ATT THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTI			NTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) ERNES	- / /	earing ARIN 6			DATE OF DEATH MONTH DATE JUEMISER	AY Y	SAR 3. TIME OF DEATH A
	4. SOCIAL SECURITY NUMBER 230 01 1678 9a. FACILITY NAME (If not institution, give s	1½ M 2 □ F 7	6 YRS.	FUNDER 1 YEAR	HOURS MIN.	DATE OF BIRTH (Month, Day, Year) ept. 2 1	918 F	BIRTHPLACE (State or Foreign Country) lorida
стов		4	SPIDAL	0	R LOCATION OF DEATH		9c. COUNTY	UCE GEORGE
DIRE	Maryland Princ	ce George's		ingside	2			10d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	4412 Maple Rd.		<u> </u>	2	20746		Unite	d States
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO		ENDENT OF HISPANIC (belty Cuban, Mexican, P 2 NO Specify:		or No 14.	RACE — American Indian, Black, Whita, etc. Specify: White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elamentary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during mos etired.)	st of working	16b. KIND OF BUS		Isurance Co.
	17. FATHER'S NAME (First, Middle, Last) Herbert C. Gearin	200	Compater	Operati	18. MOTHER'S NAME		Sumame)	isurance co.
TO BE	19a. INFORMANT'S NAME (Type/Print)	18			nd Number or Rural Route	e Number, City or Tow	n, State, Zip Co	
8	Dorothy Gearing 20a. METHOD OF DISPOSITION	20b.	4412 M		d. Morning			or Town, Stata
	1 🔀 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	M	etery, crematory or other t. Oak Ce		12/1/94	Mi		ville Md.
CAGIIII	▶ Robert E	. Evans	Prus.	Beall-	o ADDRESS OF FACILI -Evans Fun Annapolis	eral Hom	-	
dent, the meaner	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. MESENTER	CIC VA	SCULA	c 000	USION	- 540	interval Batween Onset and Death CK 6 Hours
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	G-	CONSEQUENCE OF):	1C H)	/PERTEN	VASC	RDIO	DE. YEARS.
MEDICAL CE	PART II. Other eignificent condition END STAGE R STENOSIS - P	ENAL DIS	EASE . C	AROT		PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN	DID TOBACCO USE (PEATH Y	ES NO [
YSICI	EXAMINER?	HOSPITAL:		THER:	5 Realdenca 6		-	
BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WOI		d. DESCRIBE HOW I	NJURY OCCUR	ED
TED	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, stc. (Specific	— At home, term, stre- fy)	et, tectory, office	28	t. LOCATION (Street a City or Town, State)	and Number or I	Rural Route Number,
OMPLE		CIAN: To the best of my knowle R: On the basis of examination						nuse(s) and manner on stated.
TO BE COI	29b. SIGNATURE AND TITLE OF CERTUPIES	rmela	lpha	M.D.	D 161	16		GNED (Morith, Day, Year) 129/1994
	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA	(ITEM 27) (Type, Pri	int)				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA						



		1 - STATE REGISTRAR	STATE OF MARYL			OF HEALTH AND OF DEATH	MENTAL HYGIE REG. N		
		1. DECEDENT'S NAME (First, Middle, Last) HARRY	5	6	448	HE	NOUEMBER	22 19	
PI		4. SOCIAL SECURITY NUMBER 331-09-3189	1 □XM 2 □ F	(In yrs. last birthday) 87 YRS.		DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOVEMBEL	16,190	BIRTHPLACE (State or Foreign Journal Illinois
l, 2, 3 should	TOR	90. FACILITY NAME (If not institution, give to SOUTHERN)	PRYCAND HOS	PITAL	O'C,	TOWN OR LOCATION OF	DEATH	PRIN	CECEORGES
if. Pages 1,	DIRECTOR	tos. STATE tob. COUNT	ce George's		y, town of Temple	e Hills			10d. INSIDE CITY LIMITS? t YES 2 NO
DZU physician. burial-transit permit.	FUNERAL	2600 Keating Stre	et, #415			10f. ZIP CODE	20748		n of what country? ed States
2 g g	BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR D. 6-10-42 12	2 NO	lt.	AS DECENDENT OF HISP yes, specify Cuben, Mexi YES 2 NO Spec	cen, Puerto Rican, etc.)		. RACE — American Indian, Black, Whita, etc. Specify: White
	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	life. Do NOT u	work done du se retired.)	uring most of working		USINESS/INDUS	TRY
the hospital detached for	COMPLE	7th 17. FATHER'S NAME (First, Middle, Last)		Nigr	nt Aud	18. MOTHER'S I	IAME (First, Middle, Maide		Motel
retained by 5 should be notified at	BE	Albert Guyette 190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	Eugen:	La MacKenz		orde)
ay be reta page 5 st be noti	٥	Irene T. Guyette	(Wife)	2600	Keat:	ing St., Te			
must		20a METHOD OF DISPOSITION 1. Burlel 2 Tremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	PLACE AND DATE	OF DISPOSIT ther place) OLY	Nov 23,199			y or Town, State aryland
death. tunera t. exami		21. SIGNATURE OF FUNERAL SERVICE LI	L. Belon	yer	010	d Alexande	Ferry Roa	ad, Cli	Home, Inc 6633 nton, Maryland
ed within 24 hours a completely filled in by al, cremation, or rem event, the medic		23. PART I. Enter the diseases, or shock, or heart failure. iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Di late	d the death. Do death line.	RA	In valtor	neuw	plratory arrest	t, Approximate interval Between Onset and Death
th certificate be executed by the certificate by the certificate by the certification and it Hygiene prior to burn or other traumatifications.	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	d	CONSEQUENCE OF	Ole Pi	unenl	10000	n	44
w requires that the dea been signed by the att pt. of Health and Menta 3 shows any Injury,	MEDICAL	PART ii. Other aignificant condition	a contributing to death b	out not reauiting	in the und	leriying cauae given i		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
e law has b Dept.	SICIAN:	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATI	H YES N		_	
SICIAN: The certificate it the State it or Item	YSIC	EXAMINER? 1 VES 2 NO	HOSPITAL: 1 M Inpatient 2 ER/Outp	patient 3 🗆 DOA	OTHER:				
Te this Te	ву Рну	27. NANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF JURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCUR	IEO
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED (3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	' — At home, term, :	street, tector	ry, office	281. LOCATION (Stree City or Town, Stet		Rural Route Number,
	COMPL		ICIAN: To the best of my knowledge: On the beele of examination						euse(s) end manner ee stated.
THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	O BE	296. SGNATURE AND TITLE OF CERTIFIE	52MB	Alla	dir	29 LICENSE N	4535	29d. DATE SI	IGNED (Horith, Day, Wer) 11/22/94
5		30. NAME AND ADDRESS OF PERSON WH LAXMIN, BERWA 31. DATE FILED (MODITY, Day, 1981)	100 OLD A	BRANEH	Ack	2-101 CLIA	How, MAI	ZYLANI	20735



MARYLAND 21215-0020 BALTIMORE, DIVISION OF VITAL RECORDS, P.O. BOX 68760

executed with

PHYSICIAN:

В

COMPLETED

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29a. CERTIFIER

Item

TO THE HUSPITAL OF THE FUNERAL DE MEN WITHIN 72 HO

OR

hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should once. 듉 notified be must examiner medicai filled in by t 50 the completely other traumatic event, burial. and 2 physician prior Mental Hygiene attending 10 Injury, signed by the a Health and Men shows any certificate has been h the State Dept. of I 23 Item ? 6 this c marked. After I 69 DIRECTOR hours after 28

94 36926 AMENDED #4, 11/29/94, CYW, P.G. COUNTY 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1994 FRANK 25 EARL GEF November 11:35 am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 12/03/1939 IF UNDER 24 HRS IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 346-63-1030 MONTHS DAYS. HOURS 1 X M 2 | F North Carolina 54 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DOCTORS COMMUNITY HOSPITAL DIRECTOR Lanham Prince Georges' RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince Georges' Capitol Heights YES 2 NO 10e. STREET AND NUMBE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 101. ZIP CODE 6617 Sisalbed Drive 20743 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Bleck, Whife, afc. FORCES? 1 YES 2 1 Never Married 2 Married BY Specify: **Black** 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION

18e. DECEDENT'S USUAL OCCUPATION

18e. DECEDENT'S USUAL OCCUPATION

18e. DECEDENT'S USUAL OCCUPATION ETED. 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done ife Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk COMPL Private 12th grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Willie Gee Amanda Barnes BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Willie Gee, Jr. 6617 Sisalbed Drive Capitol Hts., MD 20743 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, StatNORTH DATE 1X Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Church Cemetery Church Cemetery 11-30 WILSON COUNTY, CAROLINA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home VY 7474 Landover Rd. Landover, MD 20785 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or haart failura. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final **Onset and Daath** disease or condition_ drawer melestrice reaulting in death) wen CERTIFICATION Sequantially list conditions, DUE TO (OF AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to dasth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS

1 YES 2 NO

281, LOCATION (Street and Number or Rural Route Number, City or Town, State)

11-36-94

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one

EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 Dipetient 2 ER/Outpatient 3 DOA Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY

1 D. Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 6 Could not be 4 Homicide

1 🔯 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the filme, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 104358

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print)

BEN P. BINGHAY, MD - 9664 MARLHORD PIKE UPPER MARLHORD, OND. 20772

31. DATE FILED (Month, Day, Year) "1994 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

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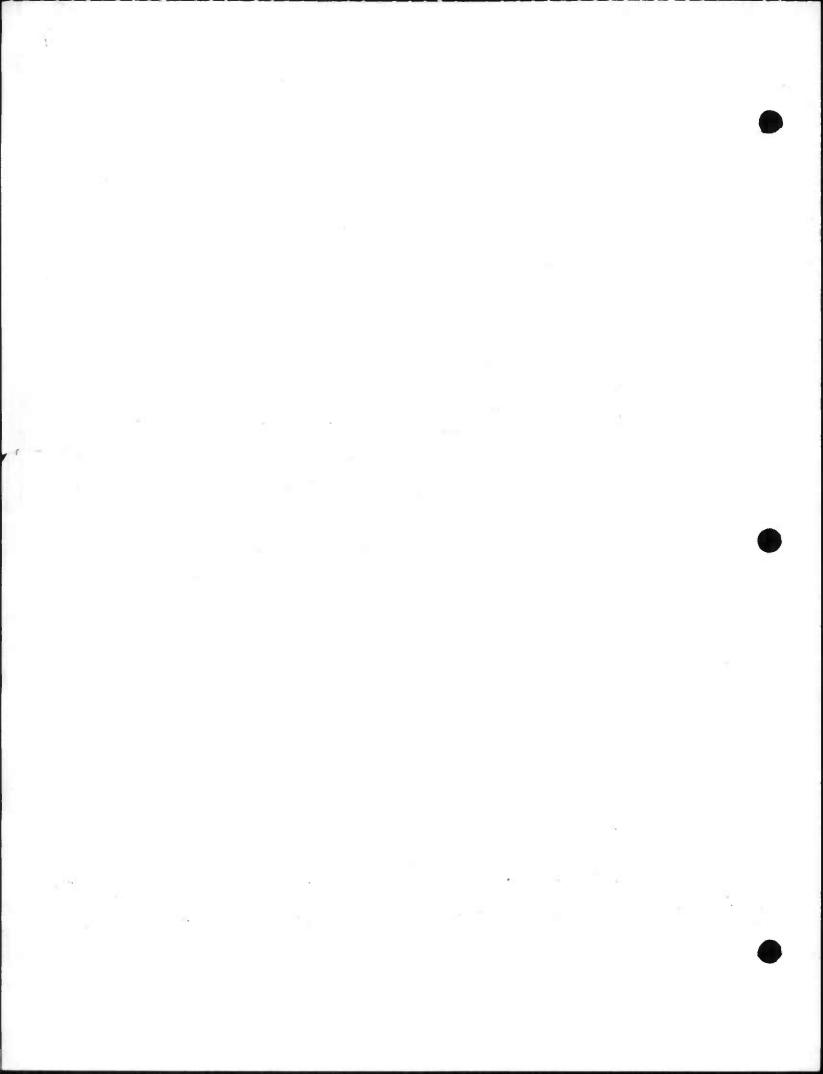
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WINDORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

	TIEGIOTTAN					ICATE				REG. NO.			
	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH MONTH DA	W	YEAR	3. TIME OF DEATH
	ELEANOR		OUISE	GAIN	IES					11/24/1		7 EAN	10:30AM
	4. SOCIAL SECURITY NUME		5. \$EX	6. AGE (In yrs. I	ast birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI-	IPLACE (State or Foreign
	244-32-7684		1 🗌 M 2 💢 🏋	65	YRS.	MONTHS	DAYS	HOURS	MIN.	8/29/19	29		h Carolina
	90. FACILITY NAME (If not in	nstitution, give s	street and number)			9b. CITY,	TOWN C	R LOCATIO	ON OF DEAT			NTY OF D	
8	3303 HAYE	ES STR	EET			Т	ANH	MAI			PRIN	ICE G	EORGE'S
5	RESIDENCE OF DEC	CEDENT									- 1(21)	-	201.02 5
DIRECTOR		10b. COUNT			10c. CIT	Y, TOWN O		TION					10d. INSIDE CITY LIMITS?
	MARYLAND		CE GEORG	E'S		LANH	IAM						1X YES 2 NO
M.	10e. STREET AND NUMBER						101	. ZIP CODE			10g, CIT		VHAT COUNTRY?
ÿ	3303 HAYE	ES STR					上	207	06			US	A
FUNERAL	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED NO	13. W	WAS DEC	ENDENT O	F HISPANIC	ORIGIN? (Specify Yee Puerto Rican, etc.)	or No-	14. RACE Black	— Americen Indian, t, White, elc.
BY	3 ₩ Widowed 4 Divo			WAR OR DATES				2 NO				Speci	
ED I	15 DEC	EDENT'S EDU	CATION	100.0	NECEDENT:	lient oo	OUDATIO						DEACK
	(Specify only	y highest grade	completed)		ECEDENT'S 'Give kind of fe. Do NOT u	work done di	uring mo	st of worldn	g	16b. KIND OF BUS	SINESS/IN	DUSTRY	
P. E.	Elementary/Secondary (0	3-12)	College (1-4 or 5	+)			cm			D2.000			
COMPLET	17. FATHER'S NAME (First, M	liddie Lest)	1 YR.		OSMET	OLOGI	ST	16 MOTE	AEDIO NAME	PVT . E (First, Middle, Maiden			
	PRINCE A.									URRELL	Surneme)		
BE	19e. INFORMANT'S NAME (7			1	OF MAILING	ADDRESS	/Ctmat a			ute Number, City or Town	- Di-1- T	- 0-4-1	
2	PATRICE GA		/ DAUGHT							FT. WASH.			ND 20744
	20a, METHOD OF DISPOSIT	ION		_	EANDDATE							City or To	
	1 X Buriet 2 Crematic	n 3 🗆 Rem	oval from State		NGTON				M.				VIRGINIA
	21. SIGNATURE OF FUNERA		CENSEE /		:					UTY	11401	. 014 /	VINGINIA
	Nua	IAM	no.	Bla	Vtoy	1 74	174	J LAN	DA£F	KINSAEU	NER A	Pov F	OME ²⁰⁷⁸⁵ R,MARYLANI
	23. PART I. Enter the di	iseeaes, or	complications the	t coused the	eeth. Do	not enter t	the mo	de of dyl	ng, auch	aa cardlec or reapi	ratory ar	rest,	Approximate
	immediate cause (Fir		List only one cau	ise on each ili	ie.								Interval Between Onset and Death
	disease or condition resulting in death)	→	Adm	notar	ino	2016	60 4	40 (Rh	Mast 1	scots	110	
	resulting in death)	,	OUE TO	(OR AS A CONS	EQUENCE O	F):	0	CK A	1	reast, 1	101/01	11/00	1 1 1 12 year
z			b.						101	he hiver	-		
I 을	Sequentially list conditi if eny, leading to imme-	diete	DUE TO	(OR AS A CONS	EOUENCE O	F):							
8	cause. Enter UNDERLYI CAUSE (Disease or Inju	ING	C.										
	that initiated events			(OR AS A CONS	FOLIENCE OF	F):							
ΙEΙ	resulting in death) LAS	I'Y	DUE TO	(0.1.10 1. 00113	- OULHOL W								
ERT	resulting in death) LAS	I'Y	DUE TO	(511 No X 00113									
A CERTIFICATION	PART II. Other algnifica	T	d			In the unc	deriying	ceuse g	lven in Pa	nrt i, 24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
		T	d			In the unc	deriying	g ceuse g	lven in Pa	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL		T	d			in the unc	deriying	ceuse g	liven in Pa		MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL	PART II. Other algorifica	T condition	d.	deeth but not	resulting					PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL		T condition	d.	deeth but not	resulting	s 🗆 N	10 🗆			PERFOR	MED?	246.	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL	PART II. Other algnifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?	T condition	ne contributing to	USE OF DE	ATH YE	S N	IO nily one)	UNC	ERTAIN	PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL	PART II. Other algnifica	T condition	d	USE OF DE. 26. PL/	ATH YE	S N TH (Check of OTHER 4 Nursi	IO I	UNC	ERTAIN	PERFOR 1 YES 2 Other (Specify)	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5	T SE CONTI	RIBUTE TO CA	USE OF DE. 28. PLJ ER/Outpetlent INJURY	ATH YE	S N TH (Check of OTHER 4 Nursi	IO Innly one)	UNC	ERTAIN sidence 8	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
BY PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6	T SE CONTO MEDICAL Pending investigation Could not be	RIBUTE TO CA HOSPITAL: 1 Inpetient 2 28e. OATE OF (Month, D) 28e. PLACE O	USE OF DE. 26. PL/ 27. PL/ 28. PL/ 28. PL/ 28. PL/ 29. Year) FINJURY — At I	ATH YENCE OF DEAT	OTHER 4 Nursi	IO	UNC	ERTAIN sidence 8	PERFOR 1 YES 2 Other (Specify) 28d. OESCRIBE HOW II	MED?	CURED	AWALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6	T SE CONTI O MEDICAL	RIBUTE TO CA HOSPITAL: 1 Inpetient 2 28e. OATE OF (Month, D) 28e. PLACE O	USE OF DE 28. PL/ ER/Outpatient INJURY ey, Year)	ATH YENCE OF DEAT	OTHER 4 Nursi	IO	UNC	ERTAIN sidence 8	PERFOR 1 YES 2 Other (Specify) 28d. OESCRIBE HOW II	MED?	CURED	AWALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide	T SE CONTO MEDICAL Pending investigation Could not be determined	RIBUTE TO CA HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 28e. PLACE O building,	USE OF DE. 26. PL/ ER/Outpatient INJURY ey, Year) F INJURY — At Matc. (Specify)	ATH YEACE OF OEA	S N TH (Check or OTHER 4 Nursi E OF TURY M	nly one) : ing Home 28c. INJI WO 1 Y	UNC 5 Re- URY AT RK? (ES 2	ERTAIN aldence 8 2 NO 2	Other (Specify) Other (Specify) Bed. OESCRIBE HOW II City or Town, State)	MED? NO NO NJURY OC	CURED r or Rural R	AWALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 290. CERTIFIER (Check only 1	SE CONT O MEDICAL Pending investigation Could not be determined	RIBUTE TO CA HOSPITAL: 1 Inpettent 2 28e. OATE OF (Month, D) 28e. PLACE O building.	deeth but not USE OF DE. 26. PL/ ER/Outpatient INJURY ey, Year) F INJURY — At t atc. (Specify) my knowledge, c	ATH YE MICE OF OEAT 3 DOA 28b. TIME INJ	TH (Check or OTHER 4 — Nursi E OF URY M	IO	UNC 5 Re- URY AT RK? ES 2 end place,	ERTAIN aldence 8 2 3 NO 2 end due to	Other (Specify) 28d. OESCRIBE HOW II 28f. LOCATION (Street a City or Town, State)	MED? NO NJURY OC	CURED r or Bural F	AWALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
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the death certificate be executed within roughs after death. Page 6 may be retained by the hospital or attending physician.	y the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit g	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
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3		man Go	dwin			DEATH	M	11 1). 6 9	YEAR	3. TIME OF D
	4. SOCIAL SECURITY NUMBER 247–48–3863	1 🗆 M 2 📆	6. AGE (In yrs. last birt	YRS. MONTHS	DAYS	IF UNDER 24 H	OC OC	ATE OF BIRTH forth, Day, Year)		Sou	th Care
TOR	9a. FACILITY NAME (If not institution, given 9512 Jeanne Could RESIDENCE OF DECEMENT	rt			ural	PR LOCATION (F DEATH		HOW:		County
- DIRECTOR		ward Count		Laure	1						10d. INSIDE C LIMITS? 1 YES 2
FUNERAL	9512 Jeanne Cou				101.	ZIP CODE	0723		US		WHAT COUNTRY
BY FUI	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	TEVER IN U.S. ARMED YES AND NO AR OR DATES	13.	If yes, spe		xicen, Pue	IIGIN? (Specify Yearto Ricen, etc.)	es or No—	14. RACE Black Speci	E — American in k, White, aic. iiy: white
LETED	15. DECEDENT'S E (Specify only highest gra Elementary/Secondary (0-12)		(Give ki	DENT'S USUAL Chind of work done NOT use retired.)	during mos	N st of working		16b. KIND OF BU			
E COMP	17. FATHER'S NAME (First, Middle, Lest) Wallace Fryal	r	BOAG	Offic	GL			ist, Middle, Meider ne Cante		lig	
TO BI	190. INFORMANT'S NAME (Type/Print) Mr. Donald Godwi	in				nd Number or F	ural Route I	Number, City or Tov	wn, State, Zip		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	Nount	Hope C	eneta	D ADORESS O	11-	-20-94 I	loren	ice.	South C
TION	23. PARI I. Enter the diseases, or shock, or heart failur IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	MOO caused the dasth.	Hope C 22 2535 Do not anta	Slack Ellic or the mod	Fune: Cott C da of dying,	auch aa	lome, P. Marylar cardiac or reap	A.)43	Approx Interval Onset a
ERTIFICATION	23. PADI L Enter the diseases, on heart failur IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a	caused the death. se on each line. OR AS A CONSECUE!	HODE C 22 2535 Do not anta CA OU NCE OF):	Slack Ellic or the mod	Fune: Cott C da of dying,	auch aa	lome, P. Marylar cardiac or reap	A.)43	Approx
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DEATH (ITEM 27) (Type, Print)

32 MEGISTRAN'S SIGNATURE
JULIA DRUGGER RENDALL

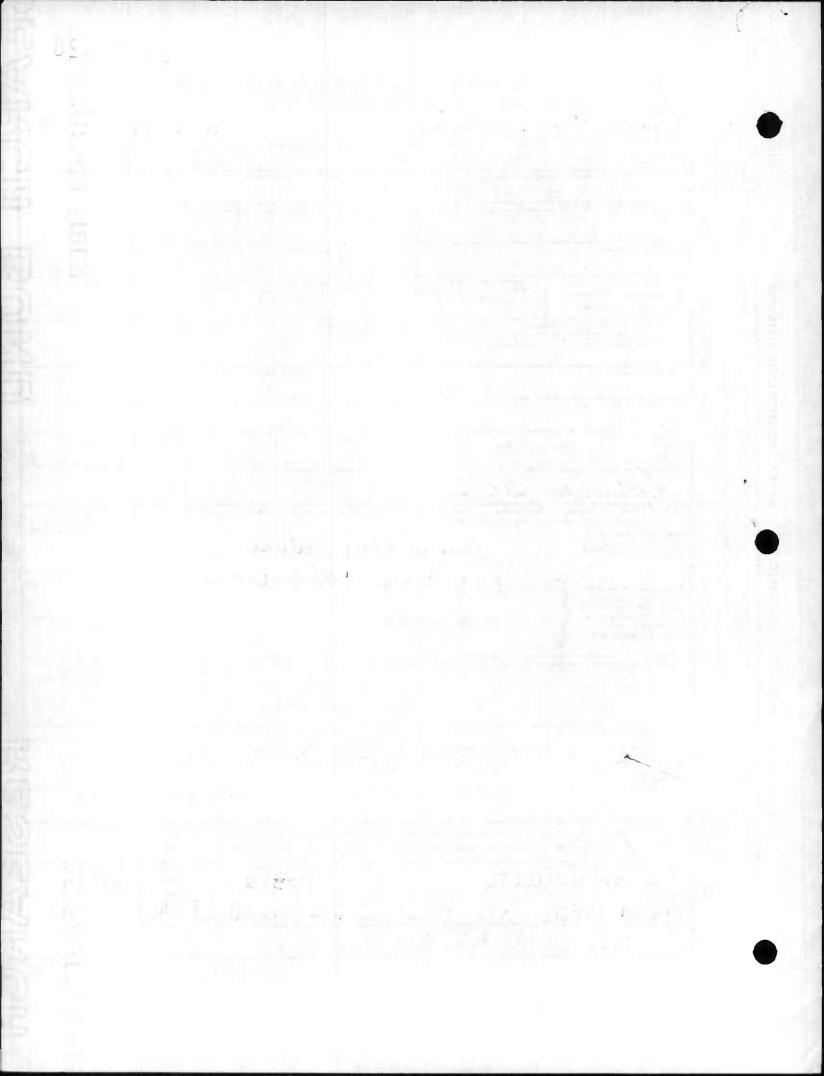
TO BE

31. DATE FILED (Month, Day, Year)

NOV 2 1 1994

DHMH-16 Rev 1/89

MD



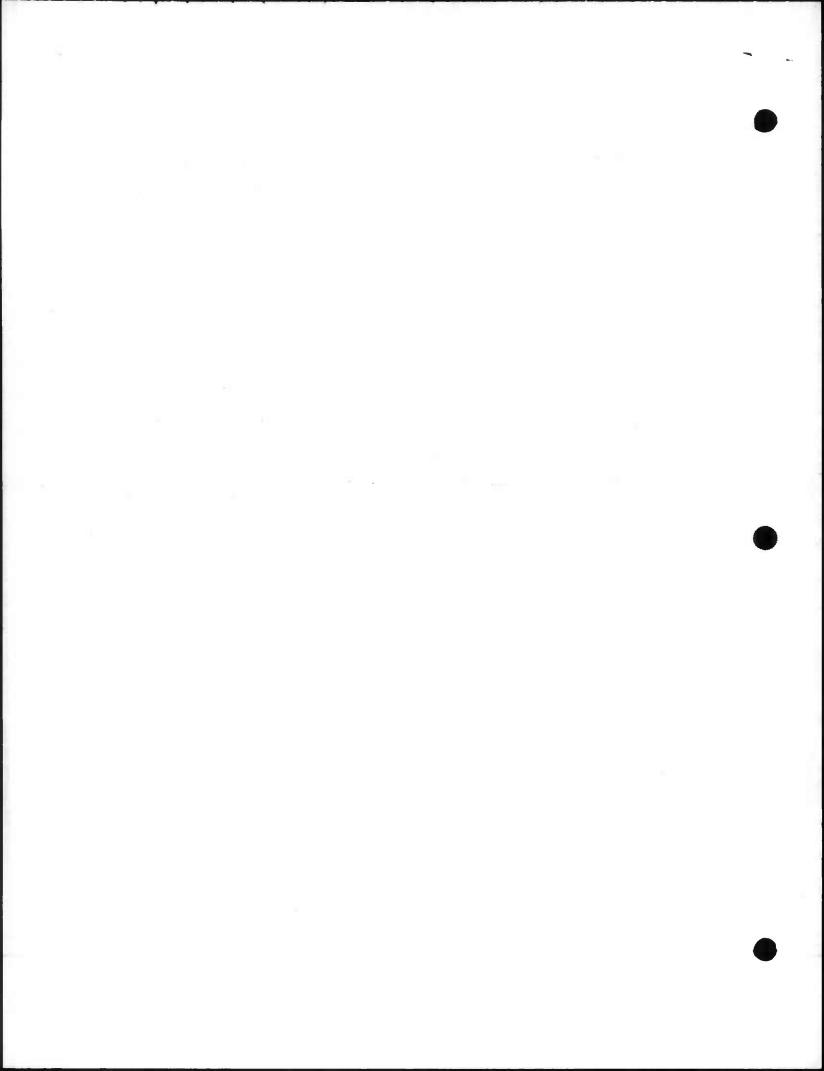
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The second of the second second
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flow to a flee death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI CERTIFIC			MENTAI	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) Wilbert M.	Gover				2. DATE MONTH Dec		1994	EAR	TIME OF OEATH	
	219-42-1006	SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) 1X—XM 2 □ F 50 YRS. 8. AGE (in yrs. last birthday) F UNDER 1 YEAR F UNDER 14 HRS. MONTHS DAYS HOURS MHN. OCT 23, 1944						BIRTHPL Country) Mary	ACE (State or Foreign y 1 a n d		
тов	90. FACILITY NAME (If not institution, give street 4017 Gill Avenueres) RESIDENCE OF DECEMENT	9						Carroll			
FUNERAL DIRECTOR	Maryland Car	10c. CITY, T	10c. CITY, TOWN OR LOCATION Hampstead				10d. INSIDE CITY LIMITS? 1 YES 2 WNO				
VERAL	4017 Gill Avenu		101. ZIP CODE 21074				10g. CITIZEI	USA	AT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS OCCEDENT EVER IN U.S. AR FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye If yea, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 MO Specify:				ee or No— 14. RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED	(Specify only highest grade completed) (Gi Elamentary/Secondary (0-12) College (1-4 or 5 +)			ve kind of work done during most of working Do NOT use retired.)				of Business/Industry			
BE COM	8 17. FATHER'S NAME (First, Middle, Last) Wilbert M. Gove	Truck	18. MOTHER'S NAME (First, Middle, Maiden S Audrey E. Thom					Surname)			
TO B	190. INFORMANT'S NAME (Type/Print) Nancy Gover		19b. MAILING AD	Gill /	Venue,	Ham	ipstea	id, Mi	D 21		
	206. METHOD OF DISPOSITION 1 © Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF PUYERAL SERVICE LICENSEE / 206. PLACE AND DATE OF DISPOSITION (Name of Cemptler place) Carmel Cemetery 12/5 Parkton, MD 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY 24. Date Carmel Cemetery Carmel Ce										
	· Steven	W. Elu	ie)	934 9	Main	St,		stead	, M	Home 21074	
	23. PART i. Enter the diseases, or co shock, or heart feliure. Li iMMEDIATE CAUSE (Final disease or condition resulting in death)	at only one cause on each	sh line.	enter the mo	de of dying, auc	h as cerd	liec or respi	ratory erreat	9	Approximate interval Between Onset and Death	
CERTIFICATION	Sequentielly list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
AL	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.						24a. WAS AN PERFOR	MED?	AN CC Of	MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
YSIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Oulpetient 3 DOA 4 Nursing Home 5 1					ce 6 Other (Specify)					
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28b. TIME O		RK?	28d. DESCRIBE HOW INJURY OCCURED						
	2 Accident Investigation 3 Suicide S Could not be 4 Homicide determined	At home, ferm, etra	me, ferm, street, factory, office 28f. L		28f. LOCA City (8f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, end due to the cause(e) end manner se stated. MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, data end piece, and due to the cause(e) and manner se stated.										
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D2432/			29d. DATE SIGNED (Month, pey, Ye			tonth, Pey, Yeer)		
F	30. NAME AND ADDRESS OF PERSON WHO	Itimore E	31 vd.	Fink	sburg	, M	D				
	31. DATE FLED (MONTH) Day, Year) 31. DATE FLED (MONTH) Day, Year)	37 REGISTRAR'S PIGNAT	URE LL					-			



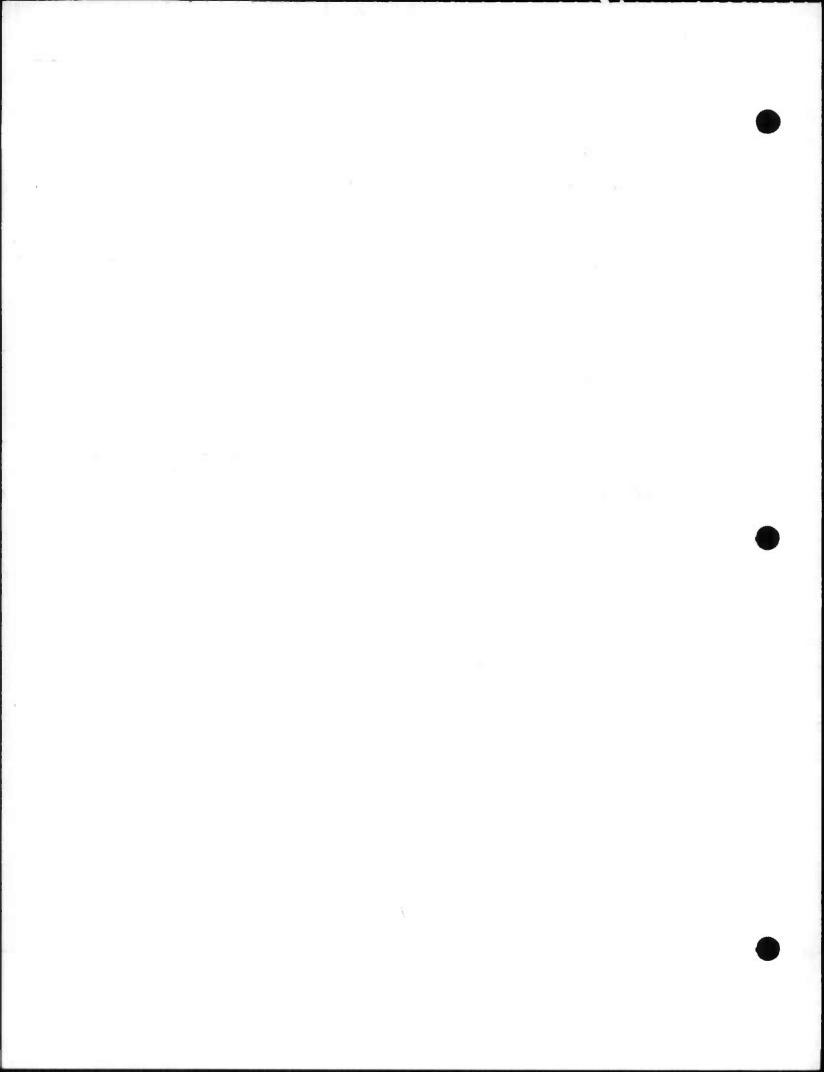
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE

AMENDED #4, 11/29/94, SEL, allegony Country Ne 9/18/18/18/9/30 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Lest) Retha Shreve Gerlach 2. DATE OF DEATH MONTH DAY NOV. 23 1994 12:08 PM								
3	4. SOCIAL SECURITY NUMBER 442 5. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S. SEX 1 S. AGE (In yrs. lest birthday) 1 S. SEX 1 S.								
TOR	98. FACILITY NAME (If not institution, give street and number) GARLOCK MEMORIAL HOME BESIDENCE OF DECEDENT 99. COUNTY OF DEATH WASHINGTON								
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1X YES 2 □ NO								
FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 829 NATIONAL HIGHWAY 21502 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S., ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No								
B≺	11. MARITAL STATUS 1 Never Merried 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes or No- If yes, specify Cuben, Mexican, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- Black, White, etc.) 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- Black, White, etc.) 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- Black, White, etc.)								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) Q 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use reliered.) HOUSEKEEPER PRIVATE HOMES								
BE COM	17. FATHER'S NAME (First, Middle, Last) THOMAS JEFFERSON SHREVE 18. MOTHER'S NAME (First, Middle, Meiden Surname) MINNIE KIMBLE								
TO B	196. INFORMANT'S NAME (Type/Print) RANDALL GERLACH 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13134 MANOR DRIVE-MT. AIRY, MD 21771								
	20e. METHOD OF DISPOSITION 1 X Burlet 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) RESTLAWN MEML. GARDENS ///38/94 LAVALE, MD								
	22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502								
	23. PART I. Enter the disease, or complicatione that caused the daeth. Do not enter the mode of dying, such as cardiec or reepiratory errest, shock, or heert fallura. Liet only one ceuse on aech line. IMMEDIATE CAUSE (Finel disease or condition resulting in daeth) DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.								
MEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO								
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
PHYSICIAN:	EXAMINER? 1 YES 2 NO								
ВУ РН	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT WORK? M 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED								
	2 Accident investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29e. CERTIFIER (Check only 20 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the firme, date end place, end due to the cause(s) end menner as stated. One) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner as stated.								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Pay, Year) 11/23/79								
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DIND J. DEL ATOKT & M. J. PILO TODO (CAL CAN'S TOTAL HAM) 31. DATE FILED (MORIA, Day, Aberl). 32. AEGISTRAR'S SIGNATURED.								
1	31. DATE FILED (MOTIL) Day, John 1994 32. REGISTRAR'S SIGNATURE								

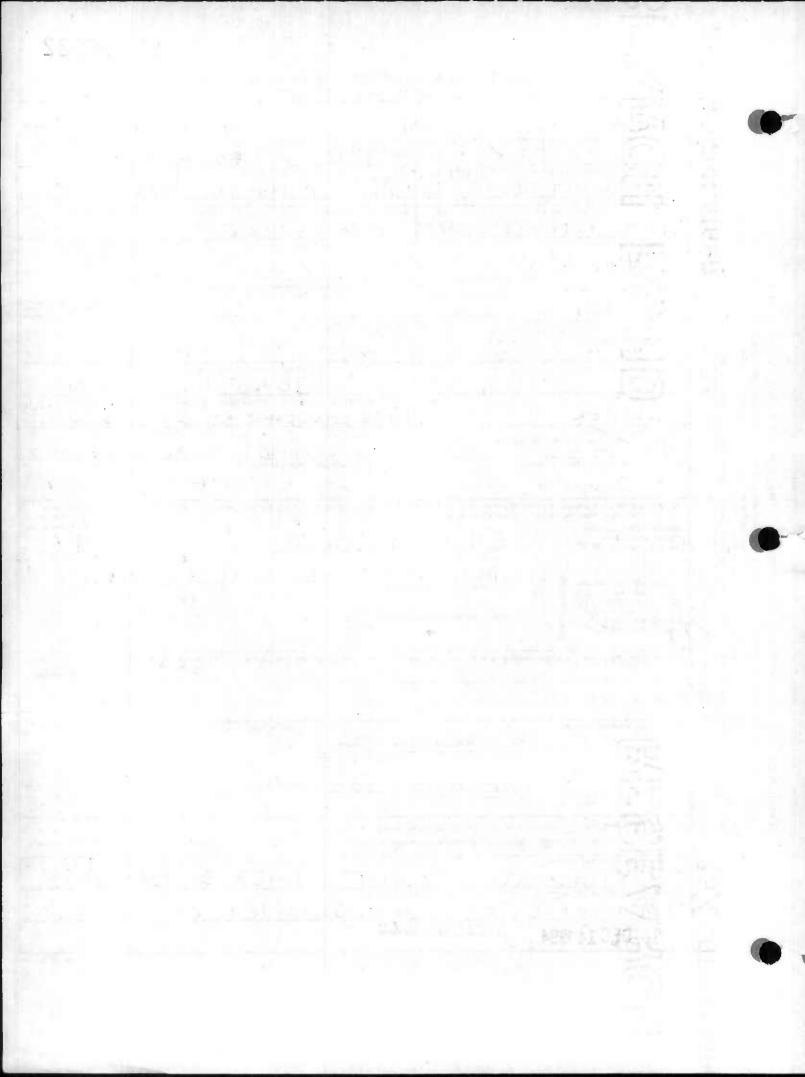


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		ENTAL HYGIEN		
		t. DECEOENT'S NAME (First, Middle, Last) HAZEL NAOMI	GROSS				2. OATE OF DEATH	_	3. TIME OF OEATH
P		4. SOCIAL SECURITY NUMBER 220-34-2469	5. SEX 6. AGE ((In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	MOTION MAIN	C. DATE OF BIRTH (Month, Day, Year) SEPT 9,		BIRTHPLACE (State or Foreign Country) MARYLAND
2, 3 should	OB	98. FACILITY NAME (If not institution, give CLEARVIEW NURSIN				PR LOCATION OF DEAT HAGERSTOW		9c. COUNTY	OF DEATH SHINGTON
permit. Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MARYLAND	VASHINGTON	10c. CIT	TY, TOWN OR LOCAT	BOONSBOR	0		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
	ERAL (100. STREET AND NUMBER 20127 BENEVOLA			101	ZIP COOE 2171		10g. CITIZEN	OF WHAT COUNTRY?
ding physician. the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	If yes, sp	ENOENT OF HISPANIC celfy Cuban, Mexicon, 2 NO Specify:	ORIGIN? (Specify Yes		RACE — American Indian, Black, White, alc. Specify: WHITE
or attend or use as	PLETED	15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	USUAL OCCUPATION work done during mose retired.)	st of working	16b. KIND OF BU	SINESS/INOUST	RY
by the hospital be detached to	E COMP	17. FATHER'S NAME (First, Middle, Last) HARRY WADE MOSER	₹				THERINE S	Surneme)	
be retained by ge 5 should be e notified at		19a. INFORMANT'S NAME (Type/Print) ELLA MAY GROSS		1		nd Number or Rural Rou LA CHURCH			O, MD 21713
age 6 may be director, page er must be		20e. METHOO OF DISPOSITION 1 X Buriat 2 Cremellon 3 Ran 4 Donation 5 Other (Specify)	noval from Stata cem	netery, crematory or o	OF DISPOSITION (Na other place) CEMETERY			CATION — CHY	or Town, State MARYLAND
death. Fe funeral	7	21. SIGNATURE & FUNERAL SERVICE OF)	M. Dean		D ADORESS OF FACIL FUNERAL HO	7606	Old Na	ational Pike MD 21713
ed within completely fille all cremation, event, the		23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Lacesson	ach line.	ascen	ling and		ratory arrest,	Approximata Interval Between Onset and Death
th certificate be execuending physician and I Hygiene prior to bur or other traumati	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с.	A CONSEQUENCE O					
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death THE FUNERAL DIRECTOR: After this certificate has been signed by the atter filed within 72 hours after death with the State Dept. of Health and Mental PORTANT: If item 28 is marked, or item 23 shows any injury, or	MEDICAL	PART II. Other algorificant condition Appendix M	ns contributing to death b	out not resulting	in the underlying	g cause given in Pa	ert I. 24e. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN: The certificate ha the State D	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Ouis	entient 3 🗆 DOA	OTHER:	ACE OF OEATH (Check			
DING PHYSIC After this ce death with the	ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		JURY WO	RK? /ES 2 NO	8d. OEŞCRIBE HOW I		
L OR ATTENDING F DIRECTOR: After thours after death item 28 is mar	PLETED	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, etc. (Spec	' — At home, farm,	straat, factory, office	2	6i. LOCATION (Street and City or Town, State)	and Number or R	ural Route Number,
HOSPITAL OF FUNERAL DI WITHIN 72 ho	COMPL	one)	ER: On the best of my know						use(a) and manner as stated.
TO THE HOSPIT TO THE FUNERA DE filed within 7	O BE	29b. SIGNATURE AND TITLE OF CERTIFIE	deal from	10	2	29c. LICENSE NUMBE	ER -5^>	29d. OATE SIG	GNEO (Month, Day, Year)
	-	Dr. Edson B. Moc	dy, 1190 Mt	. Aetna		gerstown,	MD 2174	2	
		DEC 0 6 1994	32. REGISTRAR'S SIGN	ATURE					

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TAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with mours after death. Page 6 may be retained by the hos	VAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach	feath
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	1. OECEDENT'S NAME (First, Middle, Last))		TE OF DEATH	REG. NO.		3. TIME OF OEATH				
	HELFN H	UTCHINS	INO		MONTH - DA	9 LYEAR	435 A				
	4. SOCIAL SECURITY NUMBER		yrs. last birthday) IF UN	DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign				
		1 🗆 M 2 🗷 F	YRS. MONT	B DAVE HOURS MIN.	(Month, Day, Year)	-94 N	ntry)				
	9a_FACILITY NAME (If not institution, give	street end number) SINA	HOSP (DIST	TOWN OR LOCATION OF		9c. COUNTY OF	DEATH				
OH	PG COUNTY HOSPITAL (BITH) BACTIMORE BALT. CITY										
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT		10c. CITY, TOW	N OR LOCATION			10d. INSIDE CITY				
DIR	MD PK	PINCE GEOR	1.FC H	YATTS VII	1=		LIMITS?				
	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
ERAL	7436 LANDOVER RD ZATAS U										
FUNI	11. MARITAL STATUS	12. WAS OECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISPA	ANIC ORIGIN? (Specify Yes	or No- 14, RA	CE — American Indian, ick, White, etc.				
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TES 2 NO Spec		1000	ocity: QI ACL				
EDE	15, DECEDENT'S ED	I I I	18e. DECEDENT'S USUA	CONTRACTION	Con trans on our		154/101				
<u> </u>	(Specify only highest grad	de completed)	(Give kind of work do	ne during most of working	16b. KIND OF BUS	INESS/INDUSTRY					
PL	Elementary/Secondary (0-12)	College (1-4 or 5 +)	^	1/A	1	MA					
COMPLET	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Maiden	Sumeme)					
BE C	HATTER MANAGEMENT			JOY	CE HU	TCHIN	MOLI				
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR	ESS (Street end Number or Rura	l Route Number, City or Town	n, State, Zip Code)	HYATTSVI				
F	MOTHER		7436	LANDOVE	RRD 2	1078	5 MD.				
	20e, METHOO OF DISPOSITION 1 Buriel 2 Cremetion 3 Rec	moval from State come	PLACE AND DATE OF DISI	POSITION (Name of	0	CATION — City or	Town, State				
	4 Donation 5 Other (Specify)		SINAIHO	up of Balto		rusimo	REIMI				
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE		22. NAME AND ADDRESS OF F							
	> SINA I			2401 M	1. 1) = = = = =	ere					
	23. PART i. Enter the diseases, or	complications that caused. List only one cause on ea	the death. Do not en	ter the mode of dying, su	ch as cardiec or reepi	ratory errest,	Approximate				
	IMMEDIATE CAUSE (Finel						Onset and De				
	disesse or condition resulting in death)	ENCE	EPHAL	TALOCELE							
		OUE TO (OR AS A	CONSEQUENCE OF):				1/21				
NO	Sequentially list conditions,	b MUL	TIPLE	CONGEN	ITAL AM	VomAL	1E) 1/2 m				
RTIFICATIO	Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING										
FIC	CAUSE (Disesse or Injury	(Disesse or Injury C.									
H	that initiated evente resulting in death) LAST										
CE	DADY II ON as also Misses and Miss										
AL	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS ANIABLE PRIOR TO										
EDIC					1 YES 2	□ NO	OF DEATH?				
Σ							1 YES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL			50 N AGE OF DEATH 40							
SICIAN:	EXAMINER?	HOSPITAL: OTHER:									
H	27. MANNER OF DEATH	1 Impetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Recidence 6 Other (Specify) 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED									
0	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WORK?	200. DECOMBE NOW II	WOONT OCCORED					
) BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
8	4 Homicide determined	building, etc. (Speci									
PLET	290. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of my knowle	edge, death occurred at ti	ne time, date and place, and do	us to the course(s) and man	ner se steled					
ME		NER: On the basis of exemination					e(e) end menner ee stated				
COM	29b. SIGNATURE AND TITLE OF CERTIFI										
	I 290. SIGNATURE AREA TITLE OF CERTIFIE	TOYMO = NEONATOLOGIST DHO367- 12 7-31-94									
B	The signature of Certific	- NEONAT	NOCH	TDU	0367-1	D7-	31-9V				
	30. NAME AND ADDRESS OF PERSON W	- NEONAT	OLOG-(5"	T D4	0362	17-	31-94				
B	Tolyno	O-NEONAT THO COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Print)	T D4	0362 HASP AF	>7- RA	31-94				
B	Tolyno	O-NEONAT THO COMPLETEO CAUSE OF DEA O'BRIET 32. REGISTRAT TIGHT	V, M.P	T D4	0362 HOSP OF	• 7- = BA	31-94				



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ITAL RECORDS, P.O. BOX 68760,	

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TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. LAND 21215-0020

1 . 3	FOR STATE REGISTRAR	STATE OF M			OF HEALTH AND	MENTAL HYGIE					
1. DE	CEDENT'S NAME (First, Middle, Last) Doris	lime	Hanner	s		2. DATE OF DEATH		3. TIME OF DEATH			
28	CIAL SECURITY NUMBER 86-48-7732 ACILITY NAME (If not institution, give	1 🗆 M 2 🖵 F	8. AGE (In yrs. last birthda 89 YRS	MONTHS I	DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar 15, 1	905	BIRTHPLACE (State or Foreign Country) England			
	510 Stephen Rei				ntingtown	REALH	9c. COUNTY	lvert			
	STATE 10b. COUNT	n alvert	10c. (CITY, TOWN OR	ngtown		10d. INSIDE CITY LIMITS?				
-	STREET AND NUMBER			naici	10f. ZIP CODE		1 ☐ YES 2 🔀 NO				
11. M/	510 Stephen Rei ARITAL STATUS Never Married 2 Married Widowed 4 Divorced	12. WAS DECEDENT	EVER IN U.S. ARMED YES 2 NO R OR DATES	If y	20714 S DECENDENT OF HISPA es, specify Cuban, Mexic YES 2 & NO Spec	an, Puerto Ricen, atc.)	S.A. RACE — American Indian, Black, White, etc. Specify: White				
	15. DECEDENT'S EDI (Specify only highest grad lementary/Secondary (0-12)	fe completed)	(Give kind	T'S USUAL OCC of work done dui T use retired.)	UPATION ing most of working	16b. KIND OF B	16b. KIND OF BUSINESS/INDUSTRY				
E .		College (1-4 or 5+)		emaker		C	wn Home				
	THER'S NAME (First, Middle, Lest) Charles		Rea	đ	18. MOTHER'S N	AME (First, Middle, Meide		urford			
	NFORMANT'S NAME (Type/Print)		19b. MAILI	ING ADDRESS (S	Street and Number or Rura		own, State, Zip Coo				
TAC	Norman W. Hanners 879 Vernon Road Bexley, OH 43209 20c. METHOD OF DISPOSITION 1 M Burlet 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of commetery, cremetery, cremetery or other place) Union Grove Cemetery 12-3-94 Canal Winches										
Sequif an caus	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PAR'	T II. Other algnificent condition	one contributing to d	leath but not resultin	ng in the unde	erlying ceuse given I	Part i. 24a. WAS A PERFI	N AUTOPSY DRINED? 2 NO	24b. WERE AUTOPSY FINDING ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. W	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
27. M/	Netural 5 Pending	1 Inpatient 2 I		4 🗆 Nursin	Nursing Home 5 Residence 6 □ Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED						
2 [3 [4 [Accident Investigation Suicide 6 Could not be determined	28e. PLACE OF	INJURY — At home, farr tc. (Specify)	RY — At home, farm, street, factory, office			281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)				
L (0	nal .				e, date and place, and du			nuse(s) end manner ee stated.			
296. S	SIGNATURE AND TITLE OF SERTIFIE	-mp			29c. LICENSE NU	CHAPTE .	29d. DATE SI	GNED (Month, Day, Year) 29/94			
	AME AND ADDRESS OF PERSON W	e		ype, Print)							
31. DA	DEC 1 1994	32. REGISTRAR	es signature when hardall								

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31. DATE FILED (Month, Day, Year)

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DIRECTOR: After death

been signed by the attending physician and completely fifled in by the nt. of Health and Mental Hygiene prior to burial, cremation, or removal.

Pages 1, 2, 3 should

permit.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR Wanetta Haywood 1994 November 28 1721 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign Country) DAYS 1 M 2 X F 72 368-16-5192 Dec. 15, Michigan 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Union Hospital of Cecil County E1kton Cecil RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Michigan Grand Traverse Traverse City 1 X YES 2 NO 10e, STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 49684 1240 Oak Terrace Lane U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— I1 yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify White 1 YES 2 NO Specify: ВУ 3 🔣 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION t6e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 8 Domestic Homemaker 17. FATHER'S NAME (First Miridle Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) Edward Van Dventer Mae Curtiss 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2239 Colora Road - Colora, MD 21917 Dale A. Haywood 20e. METNOD OF DISPOSITION
1

M Buriel 2 □ Cremetion 3 □ Rer 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 19AI5 Oakwood Cemetery Donetion 5 - Other (Specify) 1994 Traverse City, Michigan 21. SIGNATURE OF FUNERAL SERVICE LICENSEE P.A. Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton. MD 21921-5521 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata ehock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) Myorardial CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Obstructive Pulmonary Desex WAILABLE PRIOR TO failure COMPLETION OF CAUSE 1 TYES 2 T NO DE DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Natural м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. TO THE HOSPITAL O
TO THE FUNERAL D
BE filed within 72 ho
IMPORTANT: If No 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) end menner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIE 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Celide 023322 9 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) - 118 North Street - Elkton, MD 32. REGISTRAR'S SIGNATURE

Luke Teviden Anders

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

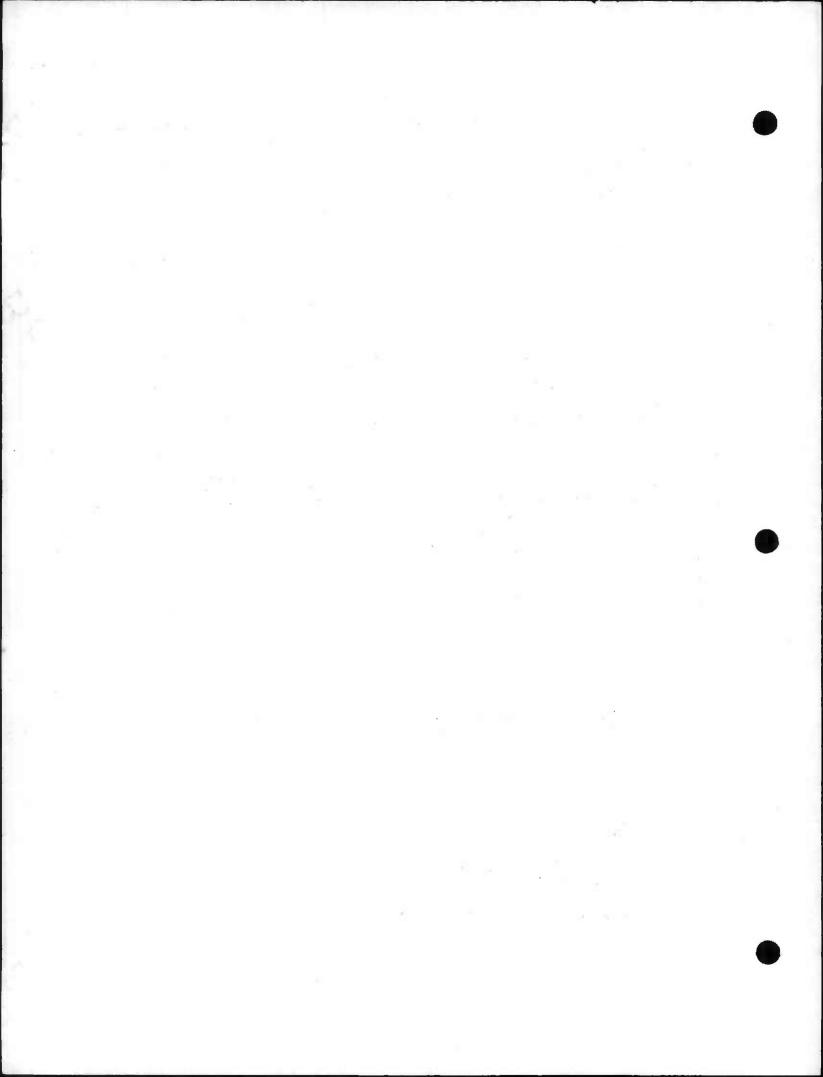
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumadic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)				•••				2. DATE	OF OEATH			3. TIME OF DEATH
- 10			Esther	Marie	Harr	ison				NONT	н ember	23.	1994	
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (in yrs.	last birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE	OF BIRTH	20,	8. BIRTI	HPLACE (State or Foreign
	222-20-7260		1 🗌 M 2 💢 F	61	YRS.	MONTHS	DAYS	HOURS	MIN.		h, Dey, Year)	1933	Mar	yland
_	9a. FACILITY NAME (If not in:							R LOCATI	ON OF DE				UNTY OF I	
<u>6</u>	Union Hospi		f Cecil (County		E11	kton					Cec	il	
EC	10a. STATE	10b, COUNTY	1		10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
Union Hospital of Cecil County Elkton RESIDENCE OF DECEDENT 106. STATE 108. COUNTY 100. CITY, TOWN OR LOCATION Maryland Cecil Elkton											LIMITS?			
	10e. STREET AND NUMBER						101	ZIP COO	E			10g. Cl	TIZEN OF	WHAT COUNTRY?
The street and number and the street and number and														
5	11. MARITAL STATUS	1040 %	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT C	F HISPAN	NIC ORIGIN	(? (Specify)	es or No—	14. RAC	E — American Indian, k, White, atc.
IL 1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, Specify Cuban, Mexican, Puarto Rican, atc.) Black, Specify Cuban, Mexican, Puarto Rican, atc.)														
								WIIICE						
(Specify only highest grade completed) (Since kind of work done during most of working life. Do NOT use retired.)														
15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) To life. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker 16. MOTHER'S NAME (First, Middle, Last) Faril Andorson														
8	17. FATHER'S NAME (First, Mi							18. MOTI	HER'S NA	ME (First,	Middle, Maide	n Sumame)		
BE		Ander	rson								ma E.			
2	Beverly A.		Botts		196. MAILING 116 S									921
					EANDDATE				DIIV					
	20a METHOD OF OISPOSITI 1 Marial 2 Crematio 4 Donation 5 Other		oval from State	cemetery, o	rematory or o	ther place)	CV	irie Of		1190	29 20c. 1 04 Ne	rank	Do 1	OWN, State
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE					O APPRE	SS OF FA	GLITY E	unera	le P	Δ	aware
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 122. NAME AND ADDRESS OF FACILITY Funerals, P.A. 103 West Stockton Street													
	23. PART i. Enter the di	seases, or c	compilcations the	t caused the	desth. Do i	not anter	tha mo	on de of dy	MD ing. suc	2192	1-552	Diretory as	rreat.	Approximate
	ehock, or he	aart fallure. I	List only Dna cau	se Dn each li	na.									Interval Between Onset and Death
immediate cause (Finel disease or condition resulting in death) e. Suddlen Cardiae Death												Onset and Destin		
	resulting in death)		DUE TO	(DR AS A CONS				JAK M						
Sequentially list conditions,														
CERTIFICATION	if sny, leading to immed cause. Enter UNDERLY!	late	DUE TO	(OR AS A CONS	EOUENCE O	F):								
잂	CAUSE (Disease or Injustinst initieted events	ny S °	DUE TO	(OR AS A CONS	EOUENCE O	F):								İ
FRT	resulting in death) LAST	T (d			_								
	PART II. Other algorifica	nt conditions	s contributing to	death but not	resulting	In the un	deriving	Cause (alven in	Part i	24n WAS /	N AUTOPSY	241	. WERE AUTOPSY FINDINGS
EDICAL								,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERF	DRMED?	240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
의										_	1 TYES	2 NO		OF DEATH?
2	DID TOBACC	O USE	CONTRIBUT	E TO CA	USE O	F DEA	TH '	YES [1 NO	σп				1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? DOSPITAL.														
	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Outpatlant		OTHER: 4 Nursing Home 5 Residence 8 (☐ Other (Specify)				
27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DI							28d. DES	CRIBE HOW	INJURY O	CURED				
à l		1 Natural 5 Pending 2 Accident Investigation					1 🗆 ነ		NO					
2 Cutoffe — I 288 PLACE DE INJURY — At home term street testons office I ass LOCATION							ATION (Street or Town, State	t and Numbe e)	or Plural i	Route Number,				
Second not be detarmined Second not be detar														
M M														s) and manner es stated.
ŭ	29b. SIGNATURE AND TITLE	fil							NSE NUM					(Month, Day, Year)
m		AC	adede	3				0	0	22		▶ /	1/23	101 h
2	36. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAUS	SE OF DEATH (IT	EM 27) (Type	Print)			1)	_			, -	7.
	S.S. Sachde	ev, M.I				t - I	Elkt	on, l	MD	2192	1			
- 1	S.S. Sachdev, M.D 118 North Street - Elkton, MD 21921 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE													
	SI. DATE PICEO (MORRII, Day,	O 4	JZ. HEGISTHA	N S SIGNATURE	2									
	NOV 3 O	94	Julia D	avidour-1	andelle									OMSEN 16 Day 1700



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE FUNERAL DIRECTOR: After this certificate has been certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should IMPORTANT: If them 28 its marked as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. INPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. N	O.		
	1. DECEDENT'S NAME (First, Middle, Last)	-				2. DATE OF DEATH		3.	TIME OF DEATH
	Cecel	ia F.	Havden			12-2-19	DAY	YEAR	170 4
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	74	S BIOTHDI A	CE (State or Foreign
		t 🗆 M 2 👽 F		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)	UE (State or Foreign
	212-05-1104	43	8 3 YRS.			1-5-191	1	Mary	land
	9a. FACILITY NAME (If not institution, give :			9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUN	NTY OF OEATH	d
6	7090 Ridge Rd.			Hano	ver		Ann	e Aru	indel
5	RESIDENCE OF DECEDENT						1		III a c I
DIRECTOR	10a. STATE 10b. COUNT			Y, TOWN OR LOCA	TION			10d	I. INSIDE CITY LIMITS?
0	MD An	ne Arundel		Hanove	r			1[YES 2 NO
4	10a. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZ	ZEN OF WHAT	COUNTRY?
FUNERAL	7090 Ridge Rd.				21076		U	.S.A.	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Y	n or No.	14. RACE —	American Indian.
	1 Never Married 2 Married	FORCES? 1 YES		It yes, sp	ecity Cuban, Mexic	en, Puarlo Rican, etc.)		Black, Wh	
BY	3 XWidowed 4 Divorced	IF TES, GIVE WAN ON	OATES	I U YES	NO Specif	ry:		Specify:	White
COMPLETED	15. OECEDENT'S EDU		18a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF B	JSINESS/INDI	USTRY	
	(Specify only highest grade Elementery/Secondary (0-12)		(Give kind of a	vork done during mo se retired.)	ost of working				
7	Elementary/Securious (0-12)	College (1-4 or 5+)	Teleph	one Op	orator	C 5.	PTO	lepho	27.0
N	17. FATHER'S NAME (First, Middle, Last)		T to Topin	one op			_	repho	ne
8	17. PAINER 3 NAME (First, MIDDIE, LESS)	TV	aufman		18. MOTHER'S NA	AME (First, Middle, Maide	n Surname)		
BE									
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To			
	Mr. Tom Allen		7094	Ridge	Rd. Ha	nover, M	D 210	076	
ı	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Ram		b. PLACE AND DATE of		eme of	OATE 20c. L	OCATION — C	City or Town,	State
- 1	4 Donation 5 Other (Specify)				emeterv	12/6 E1	kride	ee. M	D
	21. SHINATURE OF FIGURERAL SERVICE LIN	central		22, NAME A	NO ACORESS OF FA	CILITY			
- 1	▶ (/(// //	5							tchie Hw
\dashv		donn		Barr	anco Fu	neral Ho	me Se	evern	a PArkMD
- 1	23. PART LEnter the diseases, or ahock, or heart failure.	List only one cause on	ed the death. Do r	ot enter the mo	de of dying, suc	th as cardled or real	olratory erre	eet,	Approximate Intarval Between
	IMMEDIATE CAUSE (Final								Onset and Death
	disease or condition resulting in death)	· Doube	- Mya	Cardi	alin	friciti	\sim		
İ	,	DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF	7):	•	Jan Cit	V / 1		
z	h	· Severe	Ry no	rten	SIM	1			
	Sequentially list conditions, if eny, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	7:					
CERTIFICATION	cause. Enter UNDERLYING	DUE TO (OR AS	Sciera	to t	east	disec	IAC.	. !	
Ĕ.	CAUSE (Disease or injury that initieted eventa	DUE TO (OR AS	A CONSEQUENCE OF	n:					
ᇤ	resulting in death) LAST	d							
2								1	
EDICAL	PART II. Other eignificent condition	e contributing to deeth	but not reaulting i	n the underlyin	g ceuse given in	Part I. 24a. WAS A	RMF0?		RE AUTOPSY FINDINGS ILABLE PRIOR TO
용Ⅱ						1 □ YES	-	COM	MPLETION DF CAUSE OEATH?
MEI							1		YES 2 NO
-	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH YE	SINOL	UNCERTAI	N 52		, ,	, 120 2
₹	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		J OTTOLINA	<u> </u>			
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:	-1-				
¥∥	27. MANNER OF DEATH	28a. OATE OF INJURY	28b. TIM			8 Other (Specify)			
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK?	28d. OEŞCRIBE HOW	INJURY OCC	URED	
à	2 Accident Investigation				rES 2 NO				
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUR building, atc. (Sp.	Y — At home, ferm, a ecify)	treet, tectory, offic	•	281. LOCATION (Street City or Town, State	and Number (or Rural Route	Number,
Ë L	4 Homicide determined								
2 1	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of my know	wiedge, daath occurre	d at the time, data	and place, end due	to the cause(a) and me	nner an atate	d.	
COMPLETED		R: On the basis of examinati							manner as stated
	296, SHERRITURE AND TITLE OF GERTIFIE								
ᇤ	(here I bale	14			29c. LICENSE NUI		29d. DATE	SIGNEO (Mon	ith, Day, Year)
2	THE WAS THE TOTAL	reverser			0183		1	4/5/	17
- I	20. NAME AND ADDRESS OF PERSON WH	U COMPLETED CAUSE OF O	EATH (ITEM 27) (Type,	Print)	1	DIL	Na -	7/27/	
	Moges Gebremo	arram h	660 WI	I FEW	HV 203	Balto	140	XIZZ-	7
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE						
	DEC 0.8 199	14 Show	dear Randall						

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	0
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH NOVEMBER ETHEL HYMAN 994 :24A 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. last birthday) 7. DATE OF BIRTH 1912 (Month, Day, Year) NOVEMBER 4,19 IF UNDER 24 HRS. IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 😡 F NEW YORK 105 36 9887 76 YRS 4 for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO NEW YORK ROCKLAND SUFFERN 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 129 ROUTE 59 10901 UNITED STATES after death. Page 6 may be retained by the hospital or attending physician.
by the funeral director, page 5 should be detached for use as the burial-trans. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, FORCES? 1 YES 2 1 Never Married 2 Married SpecifyWHITE В 3 📉 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Ē College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME COMPL once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname Ħ SAMUEL STURMAN JENNIE BERGER BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SUSAN HYMAN 10914 SHADOW LANE COLUMBIA, MARYLAND 21044 pe 20g METHOD OF DISPOSITION
1 X Burlel 2 Cremation 3 X Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must BETH EL CEMETERY 11/28 4 Donation 5 Other (Specify) examiner TIL BIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MARYLAND 2085 or removal medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, ehock, or heart failure. List only one cause on each line. 3 Approximate filled in Intarval Between IMMEDIATE CAUSE (Finel Onset and Death item 23 shows any injury, or other traumatic event, the cremation, disease or condition _____ hem. completely 10 year OUE TO (OR AS A CONSEQUENCE OF). prior to burial, 31 mars CERTIFICATION and Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Diseese or Injury y the attending physical displaying the property of Mental Hygiene property. DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO signed by the Health and N COMPLETION OF CAUSE 1 TES 2 DINO 1 TYES 2 NO peen 0 certificate has been the State Dept. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN IN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate HOSPITAL: OTHER: 1 YES 2 YO Kinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nome 5 - Residence 8 - Other (Specify) 28 is marked, or 27. MANNER OF DEATH 28s. DATE OF INJURY this cu 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO death ВҰ Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) COMPLETED 8 Could not be DIRECTOR: hours after 4 Homicide TO THE HOSPITAL OR ATTI TO THE FUNERAL DIRECTO DE filed within 72 hours at IMPORTANT: If Item 2 29a. CERTIFIER 1 🗌 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occursd at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 26 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) DO N- WOL 0 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Lulia Davidson

1994

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TO THE HOSPITAL OR ATTENDING IN TO THE FUNERAL DIRECTOR: After be filed within 72 hours after death	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with Anous after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 5 be filled within 72 hours after detail with the State Dept. of Health and Mental Hygiene principle user for information of the mental
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 2. DATE OF OEATH DAY 1. OECEOENT'S NAME (First, Middle, Lest) 3. TIME OF OEATH YEAR Sr LEWAY avo am Hovember 1994 1258 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 🔀 M 2 🗌 F 69 July 12,1925 579 12 0382 Washington, D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Darnestown 1 YES 2 NO 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13020 Chestnut Oak Drive 20878 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No If yea, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced White 18a. DECEDENT'S USUAL OCCUPATION (Give kind at work done during most at working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elamentary/Secondary (0-12) Cartographer Army Mapping Service 17. FATHER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Raymond T. Haugh Unknown Brinklev 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel L. Haugh 13020 Chestnut Oak Drive, Darnestown, MD 20878 20a, METHOD OF DISPOSITION
1

Burlal 2

Cremation 3

Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 11/25/94 DATE 20c. LOCATION - City or Town, State Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery M00689 Avenue, Rockville, Maryland 20850-2805 23. PART Figure the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, heart feliure. List only one ceuse on each line. Intervel Between IMMEDIATE CAUSE (Finel Onset end Death disease or condition resulting in death) EREBRO VASOUAR ACCIDENT 3 DAYS OUE TO (OR AS A CONSEQUENCE OF): SCUERAL HYPERTENSION YEARS Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not recuiting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE PNEUMONIA ASPIRATION 1 YES 2 NO OF DEATH?

	25. PLACHOSPITAL:	OTHE			
27. MANNER OF DEATN Natural 5 Pending Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28d. DESCRIBE NOW INJURY OCCURED		
3 Suicide 8 Could not be datarmined	28e. PLACE OF INJURY — At ho building, etc. (Specify)	me, farm, street, fac	281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)		

M.D. (? Talwas 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

D 36552

ROCKVILLE

29c. LICENSE NUMBER

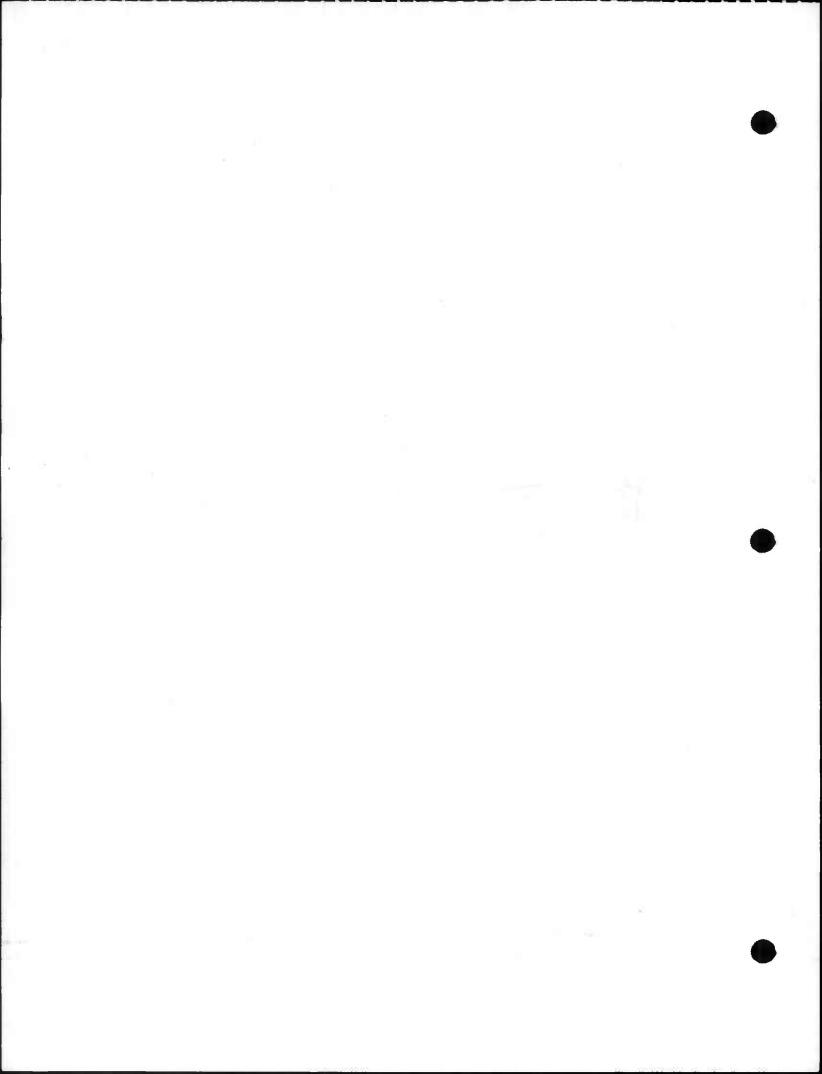
29d. DATE SIGNEO (Month, Day, Year) NOVEMBER 23 1994

MO 20852

50 W EDMONSTON DR #401

32. BEGISTRABES SIGNATURE Julia Daydson-Randall

29b. SIGNATURE AND TITLE OF CERTIFIER



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TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a function state death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	;	STATE OF N	MARYLAND /	DEPAR ERTIF	TMEN	T OF H	EALTH DE AT	AND I	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, M	liddle, Last)				·OA:		DLA		2. DATE OF DEATH			3. TIME OF DI	EATH	_
	Edith M. Ho				21	YEAR Q/L	5:30	Λ	м						
	4. SOCIAL SECURITY NUMBER	5.	SEX	6. AGE (In yrs. las	st birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	21	8. BIRTH	IPLACE (State or	Foreign	
	216-05-83	11 1	□ M ZXCXF	93	YRS.	MONTHS	DAYS	HOURS	MIN.	FEB. 14, 1	901	Country	v)		
	Se. FACILITY NAME (If not instit					9b. CIT	Y, TOWN O	R LOCATIO	ON OF DI			INTY OF D			_
DIRECTOR	NATIONAL]	DENT	RAN HO	ME			ROCI	KVIL	LE		MON	1TGO	MERY	co.	_
		OB. COUNTY BALTIM	ORE C	ITY	10c. CIT		OR LOCAT	ion 10RE					10d. INSIDE CI LIMITS? 1 YES 2		
FUNERAL	3025- WEAT	VER AV	ENUE		-		101.	ZIP CODE	214			J.S.	WHAT COUNTRY	7	
ВУ	11. MARITAL STATUS 1 Never Married 2 Ma 3 Widowed 4 Divorce	arried	WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. AR YES 2 1 AR OR DATES	MED NO		WAS DECI If yes, spe 1 YES	city Cubar	F HISPAP n, Maxica Specify	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No—	14. RACE Black Specif	CE — American Indian, ck, White, etc.		
8	15. DECED	ENT'S EDUCATE	ON		CEDENT'S					16b. KIND OF BU	SINESS/INC	DUSTRY			_
E I	Elementary/Secondary (0-12		ollege (1-4 or 5 +	Side.	ive kind of a Do NOT us	work done se retired.)	during mos	st of working	9	ł					
J M	12			T	AX C	LER	K			G	OVT.				
COMPLETED	17. FATHER'S NAME (First, Middle							18. MOTH	ER'S NA	ME (First, Middle, Maiden	Sumame)				
BE (PHEO B.	HOEP	NER							E WESSEL					
5	REV.DR. RE	(Print) EICHAR	2D	19	b. MAILING 9701	ADDRES	s (Street at EIRS	nd Number DR	or Rural I	ROCKVI	n, State, Zij LLE,	MD .	20850		
	20a. METHOD OF DISPOSITION 1 Seburial 2 Cremation		trom State	20b. PLACE				ma of		DATE 20c. LO	CATION —	City or To	wn, State	_	
	4 Donation 5 Other (Sc	pecify)	72.72	LOUD(ON P	ther place) ARK	CEM	ETE:	RY	11/25 BA	T.TTM	ORE	. MD		
	21. SIGNATURE OF FUNERAL S	PIVICE LICENS	EE	1,500		22.	NAME AN	D ADDRES	S OF FA	CILITY		CORT			
	► W.W.	Obsor	2-1							, INC.		. 5.	~		
	23. PART I. Enter the dise	ases, or com	pliestions that	caused the da	eth. Do r	ot entai	tha mod	da of dyle	ng, suc	N.W.,	ratory ar	rest.	Approxi	mete	_
J.	ehock, or hase IMMEDIATE CAUSE (Final	rt failung. List	only one cau	se on each line).								Interval Onset a	Betwe	
- 1	disesse or condition	. (Ro		7	. /	1	4	Vaile	7		Oliset a	na Dai	ittn
1	resulting in death)		DUE TO	OR AS A CONSE	ONENCE OF	Cola	ie "	CKEE	21	Mulle	42.		6	n	2
2				Arta	in a state	1.	4/-	1/2	21 -	any Arte		ni	50	210	1
<u></u>	Sequantially list condition if any, leading to immedia		DUE TO	OR AS A CONSE	QUENCE OF	ZAN (uc.	(1)	EM	cery is ic	my h	1.650	7	1	_
₹	cause. Enter UNDERLYING CAUSE (Disease or Injury	3	2	ther	02-	1,	05	12			V		50	200	-
CERTIFICATION	that initiated events		DUE TO	OR AS A CONSEC	DUENCE OF	7:							100	7	2_
E	resulting in death) LAST	d													
- 1	PART II. Other significent	conditions co	ontributing to	deeth but not r	neulting i	n the u	ndedylae	001100 0	luna la	Boot 4 Day 1970 Ave					
PART II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAL									WERE AUTOPSY AMAILABLE PRIC	R TO					
COMPLETION OF DEATH?								OF DEATH?	CAUSE						
Ξ	Demen	101								_			1 - YES 2 -	NO	
A N	25. WAS CASE REFERRED TO M	MEDICAL													
PHYSICIAN: MEDICAL	EXAMINER?	H	OSPITAL:			OTHE	Ri			eck only one)					_
¥	27. MANNER OF DEATH	11.	☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing				aing Home		idence	8 Other (Specify)		011050			
	Netural 5 Per					URY	WOF			28d. DEŞCRIBE HOW INJURY OCCURED					
B	2 Sulpido	estigation	28a, PLACE OF	INJURY At ho	me. term. e	treet fec		Co 2	-	28t. LOCATION (Street a	and Muselman	as Dumi D	ni de Africado e		_
COMPLETED		armined	building,	etc. (Specify)			iory, ornee			City or Town, State)	ina Number	or Hurai A	oute Number,		
PL	29e. CERTIFIER (Check only	ING PHYSICIAN	: To the best of	my knowledge, da	eth occurre	d at the t	lme, data :	end place,	and dua	to the cause(a) and mar	ner as stat	led.			T
8										time, date and piece, an			end manner ea	stated.	
	296. SIGNATURE AND TITLE OF					- 1	Т	29c. LICE					(Month, Day, Yea		\dashv
8	Ush	enn		mp				MI	11	18	>	11/	1 15	4	
2	30. NAME AND ADDRESS OF PE	EBRON WHO OF	MARIE ETER ANNO	F OF DEATH ATT				4	106	EL O		1/2	-1/	_	

9701-

32. ABGISTRAR'S SIGNATURE Julia Davidson-Aandall

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTOPHER SCHEMM-

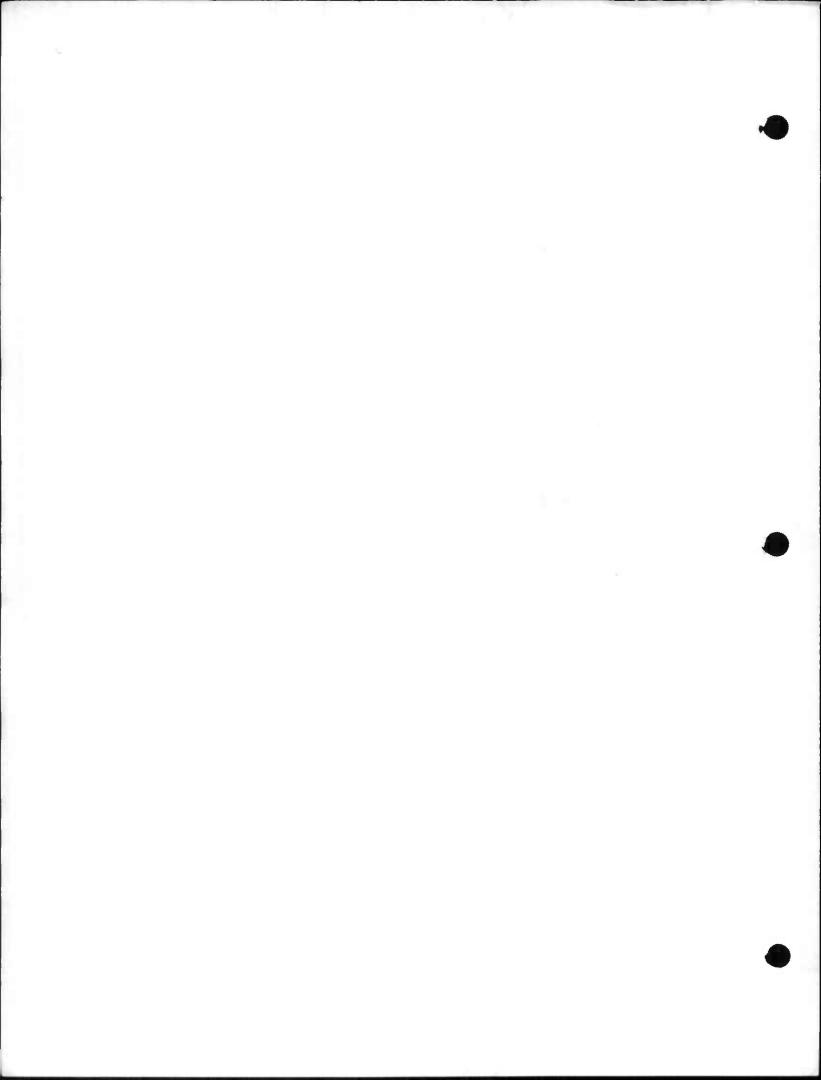
DR.

31. DATE FILED (Many), Day

Year)



VEIRS DRIVE, ROCKVILLE, MD. 20850



ospital or attending physician BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3

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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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PHYS	this	WITH	ked
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L OR	DIE.	DOL	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
PITA	ERAL	II 72	1.1
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黑	표	filed	POR
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the h	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the In THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the high TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN HAMMOND, JR. CHARLES RUSSELL 20 NOV. 94 7:00 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign 23 DAYS HOURS 1 🖾 M 2 🔲 I YRS. 578-88-2835 SEP 16 D 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 1415 DUNWOODY DRIVE OXON HILL PRINCE GEORGES RESIDENCE OF DECEDEN 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. PRINCE GEORGES OXON HILL 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1415 DUNWOODY DRIVE 20745 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian Black, White, etc. It yes, specify Cuben, Mexican, Puerto Ri 1 TES 2 XNO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES Specify: BY Specify: 3 Widowed 4 Divorced BLACK COMPLETED 15, DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY mentary/Secondary (0-12) College (1-4 or 5+) 12 SECURITY OFFICER PRIVATE INDUSTRY once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLES R. HAMMOND, SR. BE DEIDRE FORD 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 DEIDRE RAMOS 3129 LAUREL AVENUE, CHEVERLY, MD. 20785 e 20s. METNOD OF DISPOSITION
14 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION - City or Town, State HARMONY MEMORIAL PARK 4 Donetion 5 Other (Specify) LANDOVER, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY R. N. HORTON CO. MORTICIANS, INC. fortoro 600 KENNEDY STREET N. W. 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate ehock, or heart failure. Liet only one cause on each line. interval Batwean IMMEDIATE CAUSE (Fine) Onset and Death disease or condition BUNSHOT WOUND OF HEAD WOUND reaulting in deeth) CERTIFICATION Sequentially liet conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATN (Check only one) OTHER: XXYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence Other (Specify) INSIDE CAR 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending М BY 1 TES 2 NO 1615 P SUBJECT SHOT SELF 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 X Suicide 6 Could not be 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED STREET INSIDE 1415 DUNWEEDY AVE. OXON HILL, MO. 29e. CERTIFIER 1 🗌 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. XXI MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. NOV. 2 21, 1994 NO COMPLETED DATES F DEATH (ITEM 27) (Type, Print) MARIO JR 111 Penn Street, Baltimore, Mayrland 21201 MM 31. DATE FILED (Month, Day

> 9 1994 Sulia Savidson-Randelle

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DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE	OF DEATH			3. TIME OF OEATH
	SU	E SPE	ED KIRK	PATRI	CK H	IALL				NOVE	mber 29		YEAR	2:50 P
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In	yrs. last birth		R 1 YEAR	-	R 24 HRS.	7 DATE	OF BIETH	, 100	8. BIRTHP	LACE (State or Foreign
	220-38-185	0	1 M 2 X F		55 Y	'RS. MONTHS	DAYS	HOURS	MIN.	Dec	h, Day Ybar)	1938	V 7	rginia
	9a. FACILITY NAME (If not in	_	,				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY C						NTY OF DE	ATH
O.	10711 Weym		treet			Ga	Garrett Park Mor						ntgom	ery
Б	RESIDENCE OF DEC	10b. COUNT	γ		10.	c. CITY, TOWN	OR LOCA	TION						10d. INSIDE CITY
DIRECTOR	Maryland	Mo	ntgomery					t Pa	rk					LIMITS?
	10e. STREET AND NUMBER		n og omer j					f. ZIP COD				10a. CIT		1 YES 2 X NO
1	10711 Weym	outh S	treet					208	96				S.A.	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U	U.S. ARMED	13	. WAS DEC	CENOENT (OF HISPAN	IIC ORIGIN	1? (Specify Yes			- American Indian.
	1 Never Married 2 💢		FORCES? 1				tf yes, sp	ecity Cubi	in, Mexica	n, Puarto	Rican, etc.)			White, atc.
ВУ											White			
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)					ENT'S USUAL (ind of work done NOT use retired.	during mo	ON ost of world	ng	16b	. KIND OF BUS	SINESS/INI	DUSTRY	
וב	Elementary/Secondary (0		ol Tea					Public	Edu	catio	n			
COMPLET	17. FATHER'S NAME (First, M	liddle (net)	5+		30110	or rea	tener				Middle, Maiden		catio	11
		oseph	Ford								patric	,	aring	
B	19a. INFORMANT'S NAME (7		. 01 0	-	19b. MA	AILING ADDRES	SS (Street a			_	<u> </u>			
임	James V. H	a11				'11 Wey								20896
	20a. METHOD OF DISPOSIT				LACEANDE	DATE OF DISPO	SITION (No			DAT			City or Tow	n, Stata
	1 Donation 5 Other		oval trom State	- Bal	ery. cremator	ry or other place 2-Washir	naton	Crema	torv	11-				
	21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE)	22	NAME A	ND ADDRE	SS OF FA	CILITY	ices,	D A		
	D (200	en	4/	16	52.	2 7	iss c	rune ict	Avo	261.4	lues,	noin	~ MD	20010
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	shock, or h	eart failure.	List Dnly one cau	Jse Dn eac	h iine.			2000			10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -		2.72	Interval Between
	disease Dr condition Metastatic Colon Cancer 1 year													
	resulting in death) a. Due to (or as a consequence of):										7 - 3			
z														
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
걸	cause. Enter UNDERLYING CAUSE (Disease or injury													
Ē	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
l iii	d													
AL.	PART ii. Other significa	nt condition	s contributing to	death but	not reaul	ting in the u	nderlyin	g cause	given in	Part I.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS
EDICAL											1 YES 2			COMPLETION OF CAUSE OF DEATH?
ME													1	TES 2 NO
	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF	DEATH	YES	NO D	J UNC	ERTAIN	۱ 🗆 ا				,,
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26	. PLACE OF	OTHE								
YSI	1 TES 2 X NO		1 Inpatient 2		ient 3 🗆 D	OA 4 Nu	rsing Hon	6 5 X R	esidence	6 🗆 Othe	(Specify)			
	27. MANNER OF DEATH 1 X Natural 5	Pending	28a. DATE OF (Month, D		26t	b. TIME OF INJURY		PK?		28d. DES	CRIBE HOW I	NJURY OC	CURED	
B	2 Accident	Investigation				М		YES 2	NO					
8		Could not be datarmined	building,	stc. (Specify)	At home, t	larm, atreet, ta	ctory, offic	•		28t. LOC City	ATION (Street a or Town, State)	ind Number	r or Rural Ro	ute Number,
COMPLETED	29a. CERTIFIER													
P P	(Check only		CIAN: To the beat of											
8				xamination a	ind/or Invest	tigation, in my	opinion, d	leath occur	red at the	time, data	and place, an	d due to ti	he cause(s)	and manner as stated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIE	1 /					-,1,2, -, -, -,	A F OO	IBER				Month, Day, Year)
2	20 NAME AND CODES	TV 10	CV M	/)				אַכע	4590			P No	ov. 2	9, 1994
	Roy Fried, MD 10810 Connecticut Ave. Kensington, MD 20895													
			82 REGISTRA						,					
	31. DATE FILED (Month, Day, DEC 0 2	1994	Juna Hau	Jacoba	1.10	-								

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within within the fleath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

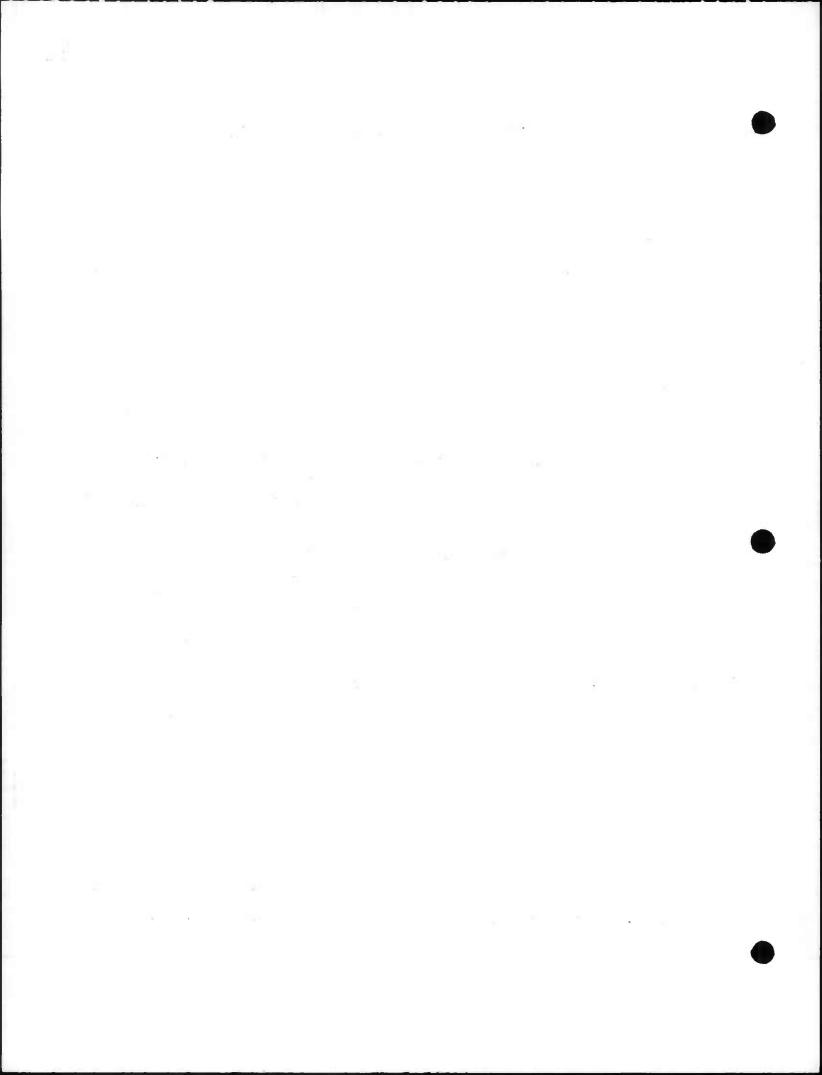
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MA			MENT OF H		MENTA	L HYGIEN	E			
1. OECEDENT'S NAME (First	, Middle, Last)						2. DATE	OF DEATH	_		3. TIME OF DEA	ATN
JOAN	LOU:	ISE	HA	ARRELS	ON		NOV		199	YEAR	11:50	Рм
4. SOCIAL SECURITY NUME	BER 5	5. SEX 8.	AGE (In yrs. las		F UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTN			LACE (State or	Foreign
213-42-1920			52	YRS.	ONTHS DAYS	Oct 6, 1942 Pennsylvar					,	ia
9e. FACILITY NAME (If not in				9		OR LOCATION OF D	EATH		77. 11.20	TY OF DE		
17608 Sequi	DIA UTIV	/e #103				rsburg			Mont	gome		
	-0. 100				TOWN OR LOCAT						10d. INSIDE CIT LIMITS?	
Maryland 100. STREET AND NUMBER	Montgo	omery		Gai	thersbu	. ZIP CODE			40. 01711		1 YES 2 C	
17608 Sequ	oia Driv	ve #103				20877					States	
11. MARITAL STATUS	1:	2. WAS DECEDENT EX	VER IN U.S. AR	RMED		ENDENT OF NISPA				14. RACE	- American Inc	Hen,
1 Never Married 2 3 Widowed 4 X Divo		FORCES? 1 [NO		ecify Cuben, Mexico 2 NO Specia		Rican, atc.)		Specify		
White												
(Specify only	y highest grade cor	mpleted)	(G	CEDENT'S US live kind of work Do NOT use n	k done during mo	ON ist of working	16	b. KIND OF BUS	INESS/IND	JSTRY		
Elementary/Secondary (0	1-12)	Cotlege (1-4 or 5+)		lemark	,		1	charity	Orga	niza	tions	
17. FATHER'S NAME (First, M	liddle, Last)		10	TCIIIGIT	VC CCI	18. MOTNER'S NA				IIIZa	ICTUIS	
Alvin		Carl	В	ain		Margare	et	Eliz	abeth	1	Smith	
19e. INFORMANT'S NAME (7	ype/Print)		19	b. MAILING AD	ODRESS (Street e	nd Number or Rural		ber, City or Town	, State, Zip	Code)		
Delinda Lyr	nelle Ha	arrelson	2	112 Cc	olumbia	Pike #B	35, A	rlingt	on, V	A 22	204	
20e. METHOD OF DISPOSITE 1 Burlel 2X Cremation 4 Donation S Other	n 3 🗆 Remova	I from State	cemetery, cre	matory or other	DISPOSITION (Na	ton Crem	0A1		CATION — C		rn, Stata	
21. SIGNATURE OF FUNERA		SEE /	Darci	MOTE-	22. NAME AT	D ADDRESS OF FA	CILITY			MD		
10/1/	Q L	2/1	1100			Funeral						
23. PAPT I. Enter the di	seasea, or con	nplications that co		827 ath. Do not	enter the mo	ist Ave,	511	ver Sp	ring,	MD	20910	
snock, or no	eart failure. Lis	t only one cause	on eech line		enter the mo	de or dynig, add	il ea car	ulec or reapil	atory erre	sat,	Approxim	Between
iMMEDIATE CAUSE (Find disease or condition resulting in deeth)	-	Pneumoni	ia, ri	ght up	per lot	oe					Onset an	
		,										
Sequentielly list conditi		Adenoma Pur to (OR	AS A CONSE	noma o	f lung.	, stage	III	3			3 Wee	ks
if any, leeding to immed cause. Enter UNDERLYI		50E 10 (0K	AS A CONSE	DUENCE OF):								
CAUSE (Disease or inju	ry C	DUE TO (OR	AS A CONSEC	DUENCE OF):							- 	
resulting in death) LAS	T d.										!	
PART ii. Other significa	nt conditions o	contributing to de-	ath but not -	seculities in 1	Oho umel - dut-		Dest !				1	
Depression						g ceuse given in	Part I.	24a. WAS AN A PERFOR	MED?		WERE AUTOPSY I	OT 9
Depression	, Deillett	tia, IIISt	JULY U	HICU	HOTTSIII			1 TES 2	X) NO		COMPLETION OF OF DEATH?	CAUSE
DID TOBACCO U	SE CONTRIB	UITE TO CAUS	E OE DEA	TU VEC		UNCERTAI					1 YES 2	NO
25. WAS CASE REFERRED TO		OIL TO CAUS			Check only one)	UNCERIAII	и Ц					
EXAMINER?		OSPITAL:		0	THER:	e 5 💢 Residenca	n 🗆 Oth	er (Specify)				
27. MANNER OF DEATH		28a. DATE OF INJ	URY	28b. TIME O	F 28c. INJ	URY AT		SCRIBE NOW IN	JURY OCC	URED		-
	Pending Investigation	(Month, Day, Y	ear)	INJUR		RK? /ES 2 NO						- 1
3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, streat, factory, office 28i. LOCATION (Street and Number or Rural Route Number, building std. (Specific)												
	determined											
29e. CERTIFIER (Check only one) 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(a) and manner ee stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 29c 11/CENSE NUMBER 29c 11/C												
There	87.00	Janel	031	mo).							- 1
30. NAME AND ADDRESS OF	PERSON WHO C	OMPLETEO CAUSE O	F OEATH (ITE	M 27) (Type, Pri	int)	D 254	IU		1/(JV. 4	27, 199	4
Oliver J. Lawless, M.D. 3801 International Dr #201, Silver Spring, MD 20906												
31, DATE FILED (Month, Day,	31. DATE FILED (MONTH, Day, Year) 32. BEGISTRAR'S SIGNATURE File Davidson-Randelle											





DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within an intervent of the fact of the fact of the fact of the fact of the state of the state of the state of the attention of the state of the state of the state of the fact of the state of the fact of the fact of the fact of the state of the fact of the state of the state of the state of the fact of the

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MEN	ITAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)						ATE OF DEATH			3. TIME OF DEAT	ГН
- 8	William Ro	bert Hipkins					vember 2	v 29, 1	YEAR QQ/I	11:30	Ам
9	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	UNDER 1 YEAR	IF UNDER 24 HRS.	7. D	ATE OF BIRTH	17,	e. BIRTH	IPLACE (State or Fo	
	579-36-8212	1 🔀 M 2 🗌 F	64 YRS.	ONTHS DAYS	HOURS MIN.		Wonth, Day, Year) y 27, 19	30	Countr	**	D 0
	9e. FACILITY NAME (If not institution, give s	treet and number)	9	b. CITY, TOWN C	R LOCATION OF D		y 21, 13	Wasn NTY OF D	ington,	D.C.	
E	10250 Westlake Drive #405 Bethesda Montgo									arv	
DIRECTOR	RESIDENCE OF DECEDENT							11011	ntgomery		
E	10e. STATE 10b. COUNT	(10c. CITY, T	OWN OR LOCAT	ION					10d. INSIDE CITY	,
		tgomery	Beth	nesda						1 TES 2 X	NO
FUNERAL	100. STREET AND NUMBER			10f	ZIP CODE			10g. CITI	ZEN OF V	VHAT COUNTRY?	
盟	10250 Westlake				20817				ited	States	
<u></u>	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER I			ENDENT OF HISPA		RIGIN? (Specify Yee	or No-	14. RACE Black	- American India c, White, etc.	n,
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		2 NO Specifi				Speci	ty:	
	15. DECEDENT'S EDU	CATION	Korean 18e. DECEDENT'S US	HAL OCCUPATION	M		16b. KIND OF BUS	INCOC/MIT	HETOV	White	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use n	done during mo	st of working		IOD. KIND OF BUS	NINC35/INL	USINT		
COMPLETED	Controlled y Co-(2)	2	Sales				Inc	uran	Ce		
<u></u>	17. FATHER'S NAME (First, Middle, Last)		Dales		18. MOTHER'S NA	ME (F	irst, Middle, Maiden		<u></u>		
BEC	William Alexa	nder Hipkins			Agnes	Go	uld				
0	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street a		_	Number, City or Town	, State, Zip	Code)		
۲	William A. Hipki	.ns	1996 M:	ilboro	Drive, H	Roc	kville,	Marv	land	20854	
- 1	20e. METHOD OF DISPOSITION 1 Buriet 2 X Cremetion 3 Rem	ovel from State	PLACE AND DATE OF	SPOSITION (Na				CATION —			
- 1	4 Donetion 5 Other (Specify)		Montgomer Montgomer	y Crema	torium,	In	c. Bet	hesd	a, M	aryland	
- 1	21. SIGNATURE OF FUNBRAL SERVICE LIE	ENSEE		22. NAME AN	A Pum	CLITY	ev Funer	al H	ome/	Bethesda	a –
	MIN XX	oan-	M00846	Chevy	Chase,	Inc	ey Funer 7557 nd 2081	Wisc	onsi	n Avenu	е
	23. PARY I. Enter the diseases, or o	omplications that cause	d tha death. Do not	enter tha mo	da of dylng, suc	h as	cardiac or reapi	ratory arr	est,	Approxima	
ł	IMMEDIATE CAUSE (Single	un out on a cause on a	ach lina.							Interval Bo	etween
	disease or condition	MYDE ADY	1. A. 11	VFAD	17.11					Ac .	-
	resulting in death)	DUE TO (OR AS	CONSEQUENCE OF):	/ Hic.	-11000			×		ACUI	E
z		a. MYOCARI DUE TO (OR AS	LEROTIC	ARD	OVASCU	14	AN E	01	ETAC	IND	310
RTIFICATION	if any, laading to immadiata	DUE TO (OR AS	CONSEQUENCE OF):								
2	CAUSE (Disease or Injury	с									
	that initiated evants resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							i	
CE		d								-	
AL.	PART II. Other aignificant condition	a contributing to death b	out not reaulting in t	ha undarlying	cause given in	Part			24b.	WERE AUTOPSY FI	
							PERFOR			AVAILABLE PRIOR COMPLETION OF C	
										OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES		UNCERTAIL	NE	r				
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOODEN	26. PLACE OF DEATH								
<u> </u>	1 🕅 YES 2 🗌 NO	HOSPITAL: 1 Inpetient 2 ER/Outs	outlent 3 DOA 4	THER: Nursing Home	5 🕅 Residence	8 🗆 0	Other (Specify)				
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJU		28d.	DESCRIBE HOW IN	JURY OCC	URED		
à	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO						
ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, stree city)	et, fectory, office		28f.	LOCATION (Street e. City or Town, State)	nd Number	or Rural R	louta Number,	
2			<u></u>	-							
COMPLE		CIAN: To the best of my know									
5	2 MEDICAL EXAMINE	R: On the beels of exemination	n end/or investigation, in	n my opinion, de	ath occured et the	time,	date end place, end	due to th	e ceuse(s)	and menner es et	teted.
	29b. SIGNATURE AND TITLE OF CERTIFIER	1//	- 11		29c. LICENSE NUI	ABER		29d. DATE	SIGNED	(Month, Day, Year)	\neg
5	della	es Ill	400		D07099			Nov	/embe	er 29, 1	994
-1	30. NAME AND ADDRESS OF PERSON WHO										
	Francis C. Mayle			Road	301, Be	the	esda, Ma	rylar	nd 2	20817	
	DEC 0 1 19	94 File Day	idion-Pandall								



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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TENDING PHYS	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Deer of Health and Mental Higher and Mental Higher prints cremation or removal	The second secon
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with an hour	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in In find within 29 hours after death with the State Deer of Health and Mental Horisene notor to hurtal cremation or or	MPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the me

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH 1223 Martha A. agenbach 11 94 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig. 1 M 2 X F 577-72-4294 37 YRS. Oct. 6, Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University of Maryland Hospital Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Delaware Sussex County Rehoboth Beach 1X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 309 Breezewood Drive 19971 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: ВҰ Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) N/A College Student 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) James R. Lewis Barbara J. McVay BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara J. Maske 209 Salt Forrest Lane, Rehobeth Beach, Delaware 20e. METHOD OF DISPOSITION
1 □ Buriel 2 ☒ Cremation 3 □
4 □ Donetion 6 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Fort Lincoln Crematory 11/25/94 Brentwood, Maryland 21. SIGNATURE OF PUNERAL PRIVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hasrt fallurs. List only ona causs on each lins. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition Ulmonary Hyper tension DUE TO (OR AS A CONSEQUENCE OF): 6mon ths resulting in death) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL WERE AUTOPSY FINDINGS **AMILABLE PRIOR TO** obesity, coagulopathy COMPLETION OF CAUSE 1 YES 2 | NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER 1 TES 2 THO 1 Dinpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER
(Check only one)

2 MENICAL EXAMINED: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 STONALUNE 11/21/99 Staff Doctor

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Per Se

B

Daniel

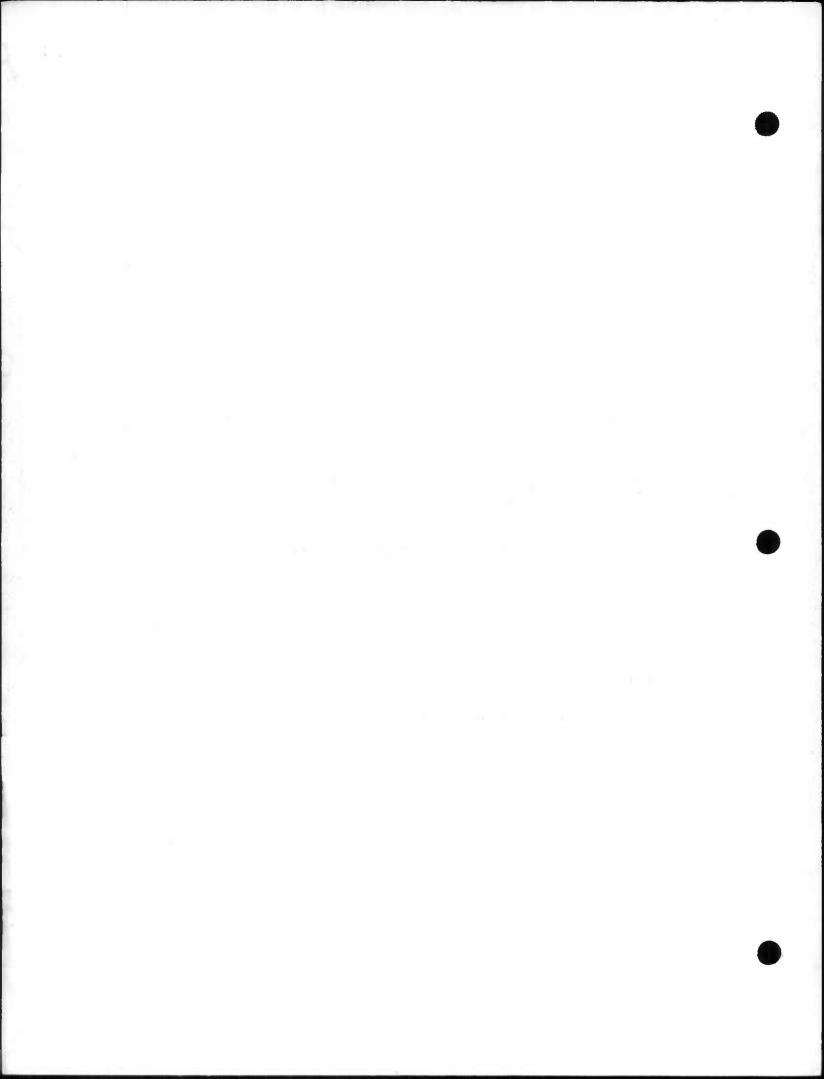
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32. REGISTRAR'S PRINTURE FUNDAMENTAL PRINTERS

MAR YLAND

Baltimore City,

HOSPITAL Baltimore, MD



94-6016-009

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AMENDED	#13	10/	25/9	CY	W. P	.G.	COL	DITY

		1 - STATE REGISTRAR	SIAIE UF N	MAKYLANU / CE				DEAT		MENTA	REG. NO	_			
		1. DECEDENT'S NAME (First, Middle, Lest, GEORGE CARL	CARL	- GEO	RGE	HA	ESL	OOP		MONT			YEAR	TIME OF DE	
		4. SOCIAL SECURITY NUMBER 227—12—7974	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS. MIN.	(Mon	OF BIRTH th, Day, Year)	1	8. BIRTHPL. Country)	: 0 4 ACE (State or	
should	~	9a. FACILITY NAME (If not institution, give	street and number)					OR LOCATIO		ATH	7.	9c. COUNT	TY OF DEAT		
1, 2, 3	STO	CALVERT COUNT!	HOSPIT	AL		PR	INC	E FR	EDE	RIC	K	CAL	VERT	COUN	4.I. X
permit. Pages	DIRECTOR	Maryland Cal	vert			ry, town of Hunt:								d. INSIDE CI LIMITS?	V.
	FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE				10g. CITIZI	EN OF WHA	T COUNTRY)
020 physician. burial-transit	ONE	5798 Mill Branch		TEVER IN U.S. ARI	MED		WAS DEC		F HISPANI	IC ORIGI	N7 (Specify Yas			tates American In	
215-0020 attending physician se as the burial-trar	B	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE V	TEVER IN U.S. ARI YES 2 N AR OR DATES 5-8-	• - 69			ecify Cuber 2 □XNO			Rican, etc.)	- 1	Specify: White		
21 alor for u	LETED	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)		(Gh	re kind of	Work done se retired.)		ON ist of working	g	180	. KIND OF BUS	SINESS/INDU	STRY		
YLAND 21 by the hospital or be detached for u at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	4+	Log	sti	cs Si	peci	alist	_		U.S. N				
MARYLAND retained by the hospit 5 should be detached notified at once.	BE CC	Carl G. Haes	100p .Sr					l .			Middle, Maiden	Surname)			
MAR retained 5 should notified	10 B	19a, INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRES:	S (Street a	nd Number	or Rural R	loute Num	ber, City or Tow	n, State, Zip C	Code)		
		Doris W. Haeslo		20b. PLACEA	798 I	Mill OF DISPOS	Brai	nch F	Road.	Hu	ntingt	OWN . I	Maryl	and 2	0639
O o ff =		1 Burial 2 Cremation 3 Ref 4 Donation 5 Other (Specify)		APPIE	ton	"Nat	iona	l Cen		ct 2	8,94 .	Arling	gton,	Virg	
BALTIMORE, after death. Page 6 may be by the funeral director, page noval. cal examiner must be		21. SIGNATURE OF PUNERAL SERVICE L		Parso	1	22. O]	name an	lexan	s of fac	Fer.	ee Fun	eral H	Home,	Inc 6	633 land
n by remo		23. PART I. Enter the diseases, or shock, or heart feilure	complications tha	t ceused the der	th. Do	not enter	the mo	de of dyli	ng, such	as cen	diac or reepi	ratory arre	st,	Approxi	
ety fille		iMMEDIATE CAUSE (Finel disease or condition resulting in death)	. Ku	LTIPLE (OR AS A CONSEC			CIEC	2							nd Dasth
executed and corr o bunial, matic even	NOI	Sequentially list conditions, If any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):													
Be phy	CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):										 			
OS, P.O. he death certifule the attending Mental Hygie		Sheriff a second	d												
In the Market	DICAL	PART II. Other eignificant condition	ns contributing to	death but not re	eulting	in the ur	derlying	g ceuse g	iven in F	Part I.	24a. WAS AN PERFOR	MED?	AM CC	RE AUTOPSY AILABLE PRIO MPLETION DE DEATH?	R TO
AL RECOF the law requires that that been signed to the Dept. of Health a m 23 shows any	: MED	DID TOBACCO USE CONT	DIBLITE TO CA	LICE OF DEAT	ru vi	-c 🖂 -	UO [LING	EDTAIN		/		17	YES 2	NO NO
VITAL AN: The law tificate has be state Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check	only one)	UNC	ERTAIN						
ICIAN: sertifica the Sta	IYSI	YYES 2 □ NO 27. MANNER OF DEATH	1 Inpetient 2 2	A			ing Hom	a 5 🗆 Res							
NG PHYSIC frer this ce eath with th	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, D	ny, Year) -0(4	28b. TIM	JURY M	28c. INJ WO 1 \begin{array}{c} \text{V}	RK?	. 1		SCRIBE HOW II ENGER O	F AUTO	IRED	LITT) IN	IPACT
TTENDI TTOR: A after d	Œ	Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE Of building,	FINJURY — At hone atc. (Specify)		street, fect	ory, office	•	\rightarrow	281. LOC	ATION (Street a or Town, State)	nd Number of			NP.
DI AL DIR AL DIR 72 hour If item	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	ER: On the best of								use(s) and men	ner as stated	1.		
TO THE HOSPIT TO THE FUNER TO THE WITHIN THE BENEFIT WITHIN	BE	30% SIGNATURE AND TITLE OF CENTIFIE	Selle	à 1				29c. LICEI	NSE NUME					, 1994	
20	2	MARIO TO GO	COMPLETED CAUS	4 . 0			St				imore				
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the nown after death. Page 6 may be retained by the hospital or attend	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as field within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IPPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	for STATE REGISTRAR	STATE OF MARY			OF HEALTH		MENTAL HYG					
	1. DECEDENT'S NAME (First, Middle, Last) Nellie	Beatrice	Haln			Ų	2. DATE OF DEAT NOVEMBET	29, 1		3. TIME OF DEATH 1:31P M		
	4. SOCIAL SECURITY NUMBER 579-34-81.25	1 □ M 2 💢 F 73	(In yrs. last birthdi	S. MONTHS	DAYS HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Yes Oct. 26,]	w)	Count	HPLACE (State or Foreign ry) Virginia		
TOR	90. FACILITY NAME (If not institution, give sti DOCTORS HOSPITAL RESIDENCE OF DECEDENT			LAN	HAM	ON OF DE	ATH		9c. COUNTY OF DEATH PRINCE GEORGES			
DIRECTOR	10e. STATE 10b. COUNTY	E GEORGES		CITY, TOWN O	R LOCATION			10d. INSIDE C LIMITS? 1 V YES 2				
FUNERAL	100. STREET AND NUMBER 7924 PIEDMONT AVE	NUE			10f. ZIP COD				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	IN U.S. ARMED 3 2 X NO DATES	11		n, Maxican	IC ORIGIN? (Specif n, Puerto Rican, atc	y Yea or No-	14. RAC Blac Spec	E — American Indian, k, White, atc.			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementery/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind life. Do NO	T'S USUAL OC of work done d of use retired.)	CUPATION uring most of working	ng	1000	BUSINESS/IN	DUSTRY	E CAPITOL		
BE CON	17. FATHER'S NAME (First, Middle, Last) JESSE S. SHERMAN				NET	LIE	BELLE JA	ACKSON		sile		
2	BETTY JONES	(DAUGHTER)					CEMPLE H			20748		
	20a. METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	oval from State 26	MASH ING	TEOF DISPOSI OF OTHER PIECE!	of disposition (Name of DATE 20c. LOCATION — City of Town, NATIONAL CEM. 12/2 SUITLAND, MARY							
	21. SIGNATURE OF FUNERAL SERVICE US	ENSEE	M859	A:		S.	POPE FUN			S E,MD. 20747		
	23. PART I. Enter tha diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reapiretory errect, ahock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) One to (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DETABBLE C PYSFUNCTION DUE TO (OR AS A CONSEQUENCE OF): C PENAL CARCINGMA DUE TO (OR AS A CONSEQUENCE OF): d.									DAYS . MANTHS		
AL	PART II. Other eignificant conditions	_			derlying ceuse of	given in F		S AN AUTOPSY	246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR		DE DEATH			ERTAIN		s 2 1140		OMPLETION OF CAUSE OF DEATH?		
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D		nly one)	LKIAII						
HYS	1 TYES 2 NO 27. MANNER OF DEATH	1 Unpatient 2 ER/Ou		4 🗆 Nursi		sidence (28d, DESCRIBE HO	OW IN ILIDA O	CURED			
面	Natural 5 Pending Investigation	(Month, Day, Year) 28e. PLACE OF INJUR		INJURY M	WORK?	NO	~	1				
ETED	3 Suicide 8 Could not be determined	building, atc. (Sp	ocify)	12			281. LOCATION (St. City or Town, S	itate)		Route Number,		
COMPLETED		CIAN: To the best of my kno								a) and menner as stated.		
TO BE	296. SIGNATURE AND ATTLE OF CERTIFIER					NSE NUMI		29d. DA	re SIGNED	(Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO GEOTGE H. BONE. 31. DATE FILED (Morith, Day, Your)	M.D. 9602F	Martin	Luthe	r King J	r. H	wy. Lank	iam, Mi	207	06		
	DECO 2 1994	O COMPLETED CAUSE OF D M.D. 9602F 32. REGISTRAR'S SIG Julia Javid	on-Randa	<u> </u>						DHMH-16 Rev 1/89		

permit. burial-transit ours after death. Page 6 may be retained by the hospital or attending physician, BALTIMORE, MARYLAND 21215-0020 use as the funeral director, page 5 should be detached for ysician and completely filled in by the prior to burial, cremation, or removal. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760, the attending physician I Mental Hygiene prior to this certificate has been signed by t with the State Dept, of Health and DIRECTOR: After the hours after death was itеш THE HOSPITAL OF THE FUNERAL D TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h

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notified at must be the medical examiner traumatic event. injury, or other shows any 23 marked, or 69 28

94 36947 Item17 2-9-95 FilmG720 W.H.Per F/H STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JAMES** HOWARD 11 94 11:25AM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country)
W. Virginia 7. DATE OF BIRTH 1/12/08 577-03-7138m DAYS HOURS MIN. 1 X M 2 | F 86 YRS. 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Prince George's Hosp. Center DIRECTOR Cheverly P.G. RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. P.G. Fairmount Hgts. MXYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 523 Eastern Ave. 20743 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rid 1 YES 2 NO Specify: 1 Never Merried 2XXMerried IF YES, GIVE WAR OR DATES Specify: Black BY 3 Widowed 4 Divorced WW II ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) vrs. Mailcarrier U.S. Post Office 17. FATHER'S NAME (First, Middle, Last) William Thomas Howard 16. MOTHER'S NAME (First, Middle, Meiden Sumame) -Edward -Howard-Angie Turner 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) <u>Christine J. Howard</u> Same as # 10 above 20e. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Harmony Mem. 11/23/94 Park Landover, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY H.S.Washington & Sons, Inc. 4925 Burroughs Ave., N.E. Xam Las Burroughs Ave., N.E. 23. PART I. Enter the diegaes, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition metastatic Prostate Cancer reaulting in death) DUE TO (OR AS A CONSFOURNCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO anemia COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSBITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 - YES 2 1 NO atlent 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Naturel 5 Pending 1 YES 2 NO В 2 Accident 26e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide

1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated, 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 039550 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4850 Forber Blud. Lanton Md. 20706 Sege C. Ma 32. PEGISTRABIC SIGN

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Section 1
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		FOR STATE REGISTRAR	STATE OF MARYL				HEALTH AND	MENTAL HYGIEN REG. NO	_				
		1. DECEDENT'S NAME (First, Middle, Last) WILL A	т н. f	tur	cHI	USON	Jr. 1	2. DATE OF DEATH OVERNOET D	^ 20 19	3. TIME OF DEATH 3:52 a M			
_		4. SOCIAL SECURITY NUMBER 216-30-2510 A	5. SEX 6. AGE ((In yrs. last	YRS. MONT	MDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) Sept. 28,	1921 N	BIRTHPLACE (State or Foreign Country) Marvland			
2, 3 should	e B	SOUTHERN /		PISPI	•	CITY, TOWN	OR LOCATION OF DI		9c. COUNTY	OF DEATH NCE GEONGE			
- -	ᇤ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT			10c, CITY, TO	AN OR LOC	ATION			10d, INSIDE CITY			
permit. Pages	DIRECTOR		e George's		Upper					LIMITS?			
Dermit		10a. STREET AND NUMBER					IOF. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
Isr	FUNERAL	11904 Fenno Roa	id				20772		U.S.	.A.			
ding physician.	à	11. MARITAL STATUS 1 Never Married 2 Married 3 X Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	XXIN	MED O	Il yea, i	ECENDENT OF HISPAI apocify Cuban, Mexica ES 2 NO Specifi	NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)		RACE — American Indian, Black, Whita, atc. Specify: aucasian			
or attending	윤	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DEG	CEDENT'S USUA	L OCCUPAT	TION most of working	16b. KIND OF BU	SINESS/INDUST	RY			
oital or	COMPLETED	Elementary/Secondary (0-12) Unknown	College (1-4 or 5+) N/A	Me.	or Mec	ed.)		Floor	aina Co				
the hospital detached for	WC	17. FATHER'S NAME (First, Middle, Lest)	IV/ IX	FIO	or Mec	lante	_	ME (First, Middle, Maiden	cing Co	nipany			
ज देव		William H. Hu	tchinson, Sr	•			The second second	rtha R.	Winds	or			
retained 5 should notified) BE	19a. INFORMANT'S NAME (Type/Print)		_	MAILING ADD	RESS (Street		Route Number, City or Tow					
		Daniel H. Hutcho		1	1904 F	enno	Road Uppe	er Marlboro	, Md 2	20772			
P 8 4		20a METHOD OF DISPOSITION 1 Description 3 Rem	oval from State Cen	PLACEA	ND DATE DO	edaany	Name of NOV . 2	23, 14949 4 20c. LO	CATION — City	or Town, State			
3 ect 6		4 Donation 5 Other (Specify)	CENSEE / /	ores	tville	Epis	copal Ch,	Cem. I	orestv	ville, Maryland			
r death. e funera al. exami		· //arem				6633	Old Alexa	andria Feri	inerai Cy Rd C	Home, Inc. Clinton, Md2073			
E 3 & a		23. PART I. Enter the diseases, or completions that ceused tha death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, Dr heart fellure. List phiy Dne cause Dn aech line. Approximate interval Between the complete interval interval Between the complete interval											
in ille		iMMEDIATE CAUSE (Final disease or condition		1	Dur	MON	ARY	DISEAS	C	Onset and Death			
rted within completely ial, cremati,		reaulting in death)	DUE TO (OR AS A	CONSEC	DUENCE OF):	107	1	FARCTO		7 011/63			
executed with and complet o burial, cren	NO	Sequentielly list conditions,	· ACHIE	JV)	YO CA	42DIA	4c Int	FARCTIO	N	IDDAYS			
ficate be execution physician and control purished by the prior to buriner traumatic	CATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEC	OENCE OF:					ŀ			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	RTIFIC	CAUSE (Disease or injury thet initiated events	C. DUE TO (OR AS A	CONSEO	UENCE OF):								
F H DE T	CERT	resulting in death) LAST	d										
at the deat by the att and Mental	SAL C	PART ii. Other aignificant condition	as contributing to deeth b	put not re	esulting in the	e underlyi	ing ceuse given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
8 = 8 = C	DIC	UTFUIAC	ARRHUTH	אוניצו	+			1 _ YES 2		COMPLETION OF CAUSE OF DEATH?			
The law requires that the has been signed at Oept. of Health is be 23 shows an	MEDIC									1 TES 2 NO			
law las law 23	AN	DID TOBACCO USE	CONTRIBUTE TO	CAUS	E OF DI								
	SICIA	EXAMINER?	HOSPITAL:	nationt 3		HER:	PLACE OF DEATH (Ch						
the the	Ì	27. MANNER OF DEATH	28a. DATE OF INJURY	patrarit 3	28b. TIME OF	28c. II	ome 5 Residence	28d. DESCRIBE HOW I	INJURY OCCUR	ED			
	IY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY		YORK? YES 2 NO						
TTENOII TOR: A after de	TED B	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spe-	— At hor	me, lerm, atraet,	factory, of	fica	281. LOCATION (Street City or Town, State)		Bural Route Number,			
TAL OR VAL DIRI	COMPLET	onel	ICIAN: To the best of my know							iuse(a) and menner as stated,			
THE HOSP! THE FUNEF flied within	ECC	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE NU			GNED (Month, Day, Year)			
THE filed	8	KRIO	Les long	1	My	300	D27			-21-94			

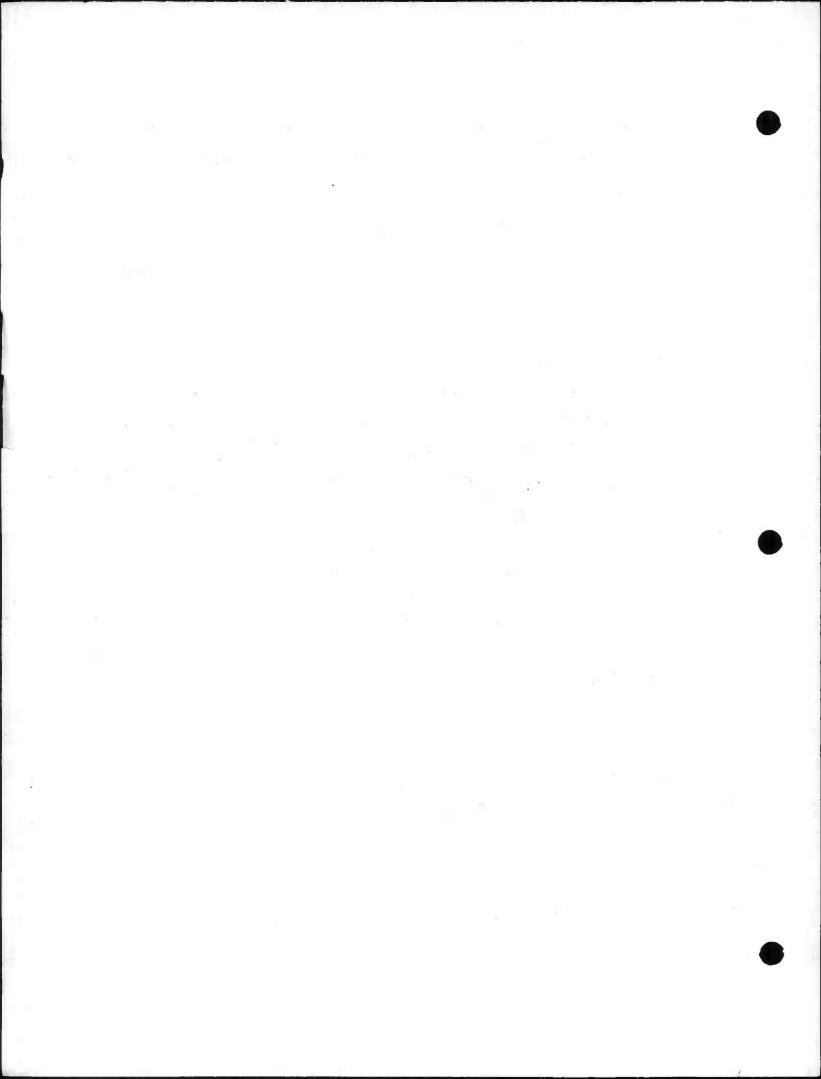
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RAJ. SAMTAN MD 9131 PLS Colonian

32. REGISTRAR'S SIGNATURE
Guha Davidson-Randale

RAJ SANTANI
31. DATE FILED (Month, Day, Year)
NOV 2 9 1994

CUMPON MA



DIVISION OF VILAE	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law i	/TO THE FUNERAL DIRECTOR: After this certificate has be	be filed within 72 hours after death with the State Dept.	IMPORTANT: It item 28 Is marked, or item 23 s
STATE OF STA	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DALLIMORE, MARTLANI	ifter death. Page 6 may be retained by the hos	the funeral director, page 5 should be detach	loval,	al examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALTH AND	MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)			Z OI DEAIII	2. DATE OF DEATH		3. TIME OF OEATH		
	Marie H. Hink	le			11 2		7:10 AM M		
	4. SOCIAL SECURITY NUMBER 5	5. SEX 6. AGE (In yrs. last		ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6. B	IRTNPLACE (State or Foreign		
	216-44-6613 9a. FACILITY NAME (If not institution, give stree	of and number)	YRS. MONTHS	TY, TOWN OR LOCATION OF D	Sept. 27,	1906	Wash.D.C.		
DIRECTOR	Manor Care Nursing	Argo			e Georges				
EC	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION			10d. INSIDE CITY		
DIA	Maryland Prince	Georges	Fores	tville			LIMITS?		
	Maryland Prince Georges Forestville 100. STREET AND NUMBER 101. ZIP CODE					OF WHAT COUNTRY?			
ER	1915 Ritchie Roa	d		20747		USA			
FUNERAL	11. MARITAL STATUS 1	2 WAS DECEDENT EVER IN HE ARE	MED 13	. WAS DECENDENT OF HISPA		or No- 14. F	RACE — American Indian,		
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 Never Merried 2 Married FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES			n, Puerto Ricen, etc.) y:		Black, White, etc. Specify:		
					Bla				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted) (Giv	CEDENT'S USUAL (we kind of work done Do NOT use retired,	during most of working	166. KIND OF BUS	SINESS/INDUSTF	RY.		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)			11.000	1 (
MO	17. FATHER'S NAME (First, Middle, Last)	Z Cle	rk Typs		ME (First, Middle, Malden		Service Com.		
	Charles H. Hodg				A. Dent	surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	19b	MAILING ADDRES	SS (Street and Number or Rural		n. State. Zio Code	p)		
5	Charles H. Dent	11	915 Ri	tchie Road	20747		,		
	20a. METNOD OF DISPOSITION	20b. PLACEA	ND DATE OF DISPO	SITION (Neme of		CATION City of	or Town, State		
	1 Burial 2 KCremation 3 Ramova 4 Donation 5 Other (Specify)		natory or other place	Crematory	11/24 11	ovenda	cio VA		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	21	NAME AND ADDRESS OF FA	CHTY Filneral	Home	Tnc		
	I wood	Z XV	43	308 Suitlar	nd Rd. Su	itland	1.MD 20746		
	23. PART I. Enter the diseesea, or con	23. PARV I. Enter the diseases, or complications that coursed the death. Do not enter the mode of dying, such as cerdiac or reepiretory errest, Approximate							
	ehock, or heert fallure. Liet only one ceuse on eech line.						Interval Between Onset and Death		
	disease or condition Pneumonia e. Pneumonia								
	reculting in death) e. THE CHILD HE A DUE TO (OR AS A CONSEQUENCE OF):						3 weeks		
z		Congestive Heart Failure							
5	If any, leading to immediate								
S	cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
				lo carcino	. m. a				
CERTIFICATION	resulting In deeth) LAST Kidney mass, possible carcinoma								
AL (PART II. Other significent conditions contributing to deeth but not reculting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
S	Armte abdominal anguryem - COM						AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Ä	Anomic - c/n 1- cub cracknoid homorrhago					1 YES 2 NO			
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
S	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)								
NS.		☐ Inpetient 2 ☐ ER/Outpetient 3	□ DOA 4 □ Nu	reing Nome 5 🗆 Rasidence	8 🗆 Other (Specify)				
PHYSICIAN: MEDIC	27. MANNER OF OEATN 1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE NOW I	NJURY OCCURE	D		
BY	2 Accident Investigation	M 1 YES 2 NO							
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	ne, farm, street, factory, offica		261. LOCATION (Street a City or Town, State)	iral Route Number,				
	29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner or stated								
M	(Check office) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								
BE	Louis C. Clourballe US 290. LICENSEN D420					NED (Month, Day, Year) - 23 - 94			
임	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					/ /			
	Alain G. Champaloux MD - 14314 Old Marlboro Pike, Upper Marlboro, MD 20772								
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAB'S SIGNATURES	OTO HOL	IDOIO IIRE,	opper marri	DOLO, M	LD ZUIIZ		
	NOV 2 9 1994	32. BEGISTRAB'S SIGNATURE	marco						

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE CHANGE OF THE PARTY OF THE	IMPURIANT INTER 28 IS MARKED, OF IEM 23 SPOWS ANY INDIVIOUS ORDER TRAUMATIC EVENT, THE MEDICAL EXAMINER MUST BE NOTIFIED AT DAKE	INDOCTANT: If from 22 is marked as item 22 shaws one interest or ather transmission are made an accided as accided as accided as	a neam a	
ie mark	THE WOOD WITH IT IS DOUGH WITH THE CARRIE COUNTY OF THE WOOD THE W	FIND WITH 12 HOURS also Leavil With the State Cept. Of regular and mental hypere prior to density, of entires.		THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.
the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. INDODITABLE Hom 28 is marked, or Ham 22 shows any interpretation or other theorems the marked as a marked.	er death w	er death w	as done	G PH
or death w	er death w	er death w	A Arier In	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
R. After this or death w	R. After this er death w	R. After this ar death w	R. After thi	THE PARTY OF STREET, WAS ASSESSED. TO SEE ASSESSED.
R. After this or death w	Z 00 5	R. After this er death w	R. After thi	

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTA	L HYGIEN	E			
	1. OECEDENT'S NAME (First, Middle M.	ichael Leo	eo Herndon			2. DATE OF DEATH MONTH 11 - 24 - /534 11:10 A M					
OR	4. SOCIAL SECURITY NUMBER 577-62-9042	5. SEX 8. AGE		F UNDER 1 YEAR DAYS DAYS	IF UNDER 24 HRS. HOURS MIN.	UNDER 24 HRS. 7. DATE OF BIRTH				ACE (State or Foreign	
	98. FACILITY NAME (If not institution, give street and number) 4460 Diane Court (Residence) 9b. CITY, TOWN OR LOCATED Prince Free					F DEATH 9c. COUNTY OF DEATH					
DIRECTOR		OUNTY 10c. CITY, TOWN OR LOCATION 1 Vert Prince Frederick				10d. INSIDE CITY LIMITS?					
FUNERAL	100. STREET AND NUMBER 4460 Diane Court			101. ZIP CODE 20678				10g. CITIZEN OF WHAT COUNTRY? United States			
COMPLETED BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	N U.S. ARMED 2 NO NATES 2-23-73	2 ☐ NO It yes, specify Cuben, Mexican, Puarto R 1 ☐ YES 2√NO Specify:						White, atc.		
	15. DECEDENT (Specify only higher Elementary/Secondary (0-12)	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of work) (Give kind of work done during most of work) (Give kind of work done during most of work) (Ifte. Do NOT use retired.) Machinist			N st of working	Naval Research Lab					
BE COM	17. FATHER'S NAME (First, Middle, L Aubrey Herndon	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S P			Jeanne	AME (First, Middle, Meiden Surnerne)					
2	Laura Herndon	(Wife)	4460 Di	ane Cou		Route Num	ber, City or Tow rederic	n, State, Zip C Ck , Ma	ryla	ınd 20678	
	206. METHOD OF DISPOSITION 1 M Burisi 2 Cremestion 3 Removal from State 4 Donatton 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of Maryland Vetterans Cem. Nov 29,94 Cheltenham, Maryland 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Maryland 20735										
NO	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions. Sequentially list conditions.										
CERTIFICATION	that initiated eventa reautiting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.										
AL	PART ii. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.					PERFORMED? 1 YES 2 NO OF DEATH		PRE AUTOPSY FINDINGS MAILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
XSI	1 TYES 2 THO	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 DOA 4	THER: Nursing Home	5 Residence	6 🗆 Othe	r (Specify)	y)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pendin 2 Accident Investig		26b. TIME C INJUR	Y 26c. INJU Y WOI M 1 Y	RK?	28d. DESCRIBE HOW INJURY OCCURED					
	3 Suicide 6 Could not be datarmined 6 Could not be datarmined 286. PLACE OF INJURY — At home, farm, street, tactory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) end manner as stated.										
TO BE C	29b. SIGNATURE AND TITLE OR CERTIFIER LA CALL 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								11-25-(98 6		
	Dr. Katzen 8926 Woodyard Road, Suite 201 Clinton, Maryland 20735										
	NOV 2 9 1994 32. REGISTRAR'S SIGNATURE Julia Savidson-Randale										

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) ROSE	GA	ARNER	HUD	NALL	2. DATE OF DEATH NOVEMBER 2	2,1994	3. TIME OF DEATH 9:41 P M		
	201 10 1000	234-40-7688 1 - M 2 X F 68 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Oct 25, 1								
TOR		90. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL LA PLATA CHARLES								
DIRECTOR	10a. STATE 10b. COUNTY	e George's		rown or Locat			10d. thiside city Limits? 1 ☐ YES 2 ☐ NO			
FUNERAL	100. STREET AND NUMBER 6117 Wesson Drive	2		101	2074	6		citizen of what country?		
B⊀	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Olvorced	12. WAS OECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes, sp	ENDENT OF HISPAN ocity Cuban, Maxica 2 XXVO Specify	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	8	ACE — American Indian, lack, White, etc. pocity: Inite		
COMPLETED	15. DECEDENT'S EDUC/ (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	life. Do NOT use n	k done durina mo	DN st of working	Own H		Y		
BE COM	17. FATHER'S NAME (First, Middle, Last) Gordon Garner					ME (First, Middle, Maiden ie Mae Per		1		
TO B	19a. INFORMANT'S NAME (Type/Print) Constance H. Booh	ıer	195. MAILING AD 6117 We	DRESS (Street a	nd Number or Rural F rive, Ca	np Springs	n, State, Zip Code	746		
	20a. METHOD OF DISPOSITION 1	val from State	PLACE AND DATE OF I	ory Nov	26,1994	Cli	cation – city o nton, Ma	aryland		
	21. SIGNATURE OF FUNERAL SERVICE LICE	Marzola		Old Al	.exander	Ferry Road	d, Clint	ome,Inc 6633 con,Maryland		
	23. PART I. Enter the diseases, or co ahock, or heart failura. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	lat only ona cause on ea	ch lina.	. 1	da of dying, such	as cardiac or reap	ratory arreat,	Approximata Interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
MEDICAL C	PART II. Other significant conditions	contributing to death but	t not resulting in I	the underlying	cause given in	Pert I. 24s. WAS AN PERFOR	PERFORMED? AVAILABLE P			
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. WAS CASE REFERRED TO MIDICAL 29. PLACE OF DEATH (Check (inty one))									
HYSIC		HOSPITAL: 1 ☐ Inpettent 2 BEFOUDE 28s. DATE OF INJURY	28b. TIME 0	F 28c INJ		6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED			
Manufacture Manufacture								w/ Route Mumber,		
TO BE COM	296. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examination	W	1	29c. LICENSE NUM			se(s) and manner as stated, HED (Month, Day, Year)		
	30. MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (AND PRINT) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Author Davidson—Randall									

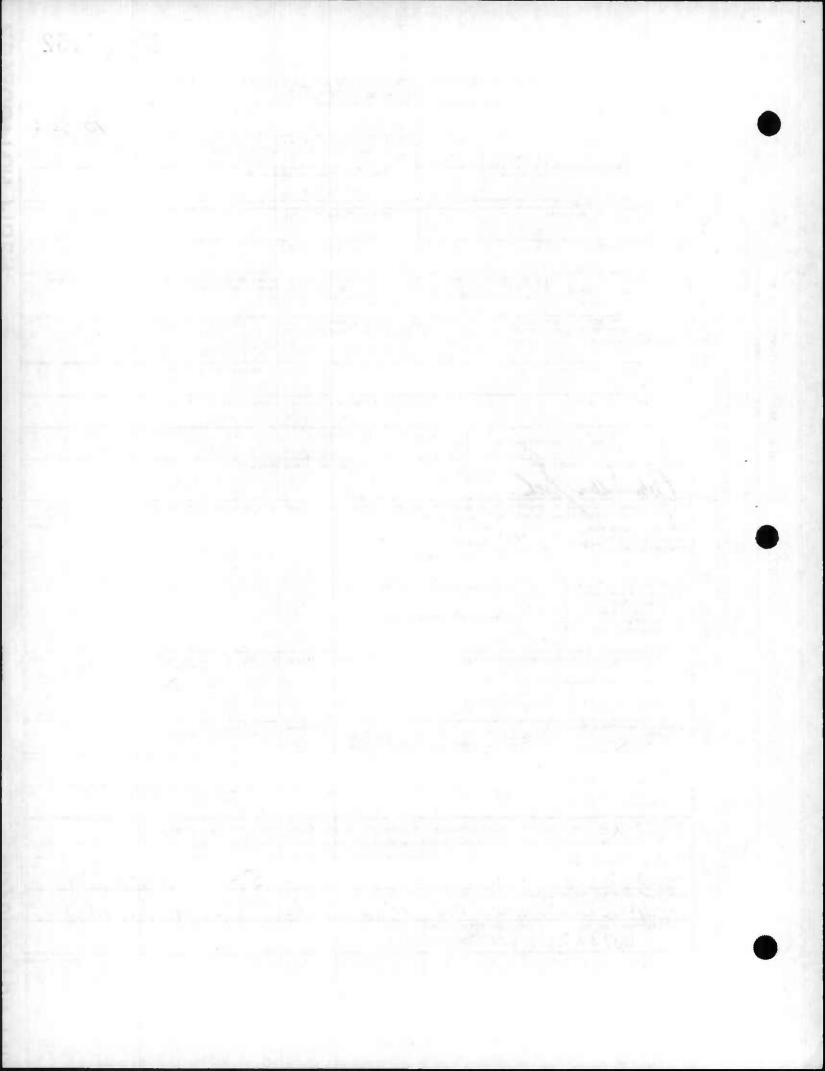
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	-

1	-	STATE REGISTRAR
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DE	DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	C. Hill 6. AGE (In yrs.		IF UNDER	YEAR	IF UNDER	24 HRS. 3	NOV.		994	10/50 /
	21.2-30-700	3	1 M 2 K F	51	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, 1		Cour	Maryland
	9a. FACILITY NAME (If not in	natitution, give	etreet end number)		-	9b. CITY,	TOWN	OR LOCATIO	N OF DEAT			UNTY OF	A
RECTOR													
EC	10e. STATE	10b. COUNT	Υ		10c. CI	TY, TOWN O	R LOCA	TION					10d. INSIDE CITY
ä	Maryland	Ноча	ard		Co	Lumbia	a						LIMITS?
AL	10e. STREET AND NUMBER						10	f. ZIP CODE			10g. CI	TIZEN OF	WHAT COUNTRY?
FUNERAL	6642 Sene	ca Dri	ve					21046				USA	
BY FUI	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Dive			NT EVER IN U.S. I YES 2 WAR OR DATES		H	yes, sp	CENDENT OF CUBER 18 2 1 1 NO	, Mexican,	ORIOIN? (Spec Puerto Rican, a	olfy Yes or No— nc.)	Bie	CE — American Indian, ck, White, atc.
ED		EDENT'S EDU			DECEDENT'S					16b. KIND	OF BUSINESS/II		
E	Elementary/Secondary (College (1-4 or 5	+)	(Give kind of life. Do NOT u	ise retired.)		7	1.				
MPI	12			Vq	minis	trati	on	Offic	er	Fede	ral Gov	vern	nent
BE COMPL	17. FATHER'S NAME (First, A. J. Ernes	st Coo	ney					The state of the s			Meiden Surneme) et Zim		an
10	19e. INFORMANT'S NAME (or Town, State, 2		
	John Richar		L				_		Col		Maryla		21045
	20a. METHOD OF DISPOSIT	on 3 🗆 Ren	novel Inom State	cemetery,	Cremetory or	other placa)					Oc. LOCATION -		
	4 Donation 5 Other		colore	Balt	-Wash			TY, I		11-94	Laure	1, 1	aryland
	11111.)535						Home, !	P.A.		
	23. PART I. Enter the d		ll			E1.	lic	ott C	ity,	Md 210	343		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
	PART II. Other significa	ant conditio	na contributing to	death but no	t resulting	In the une	leriyin	g cause g	Ivan in Pa		AS AN AUTOPS'	r 24	Sb. WERE AUTOPSY FINDS AMAILABLE PRIOR TO
MEDICAL											YES 2 XNO		COMPLETION OF CAUS OF DEATH?
ME										1 10			1 YES 2 NO
ä													
SICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTHER		LACE OF DE	ATH (Check	k only one)			
YS	1 TES 2 NO		1 - Inpatient 2		1	4 🗆 Nurs	ng Hon			Other (Speci			
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 2 Accident	Pending Investigation	28s. DATE OF (Month, I	FINJURY Day, Year)	26b. TII	ME OF JURY M	W	JURY AT ORK? YES 2		REG. DESCRIBE	HOW INJURY O	CCURED	
ETED E	3 Sulcide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28i. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)										Route Number,		
COMPLE	anal		ICIAN: To the best of a										(e) end menner ee state
BE	29% SIGNATURE AND TITLE	OF DERTIFIE	unin	0	W			29c. LICE	95	ER 26	29d. D/	TE SIGNE	D (Month, Day, Year)
10	FRANC	is K	RUNC	mo	N		ca i	AR	ts	Co	lumb.	1a,	MD
	31. DATE FILED (Month, Day,		32. REGISTRA	davelant	Randall								



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DIVISION OF VITAL RECORDS, P.O. BOX

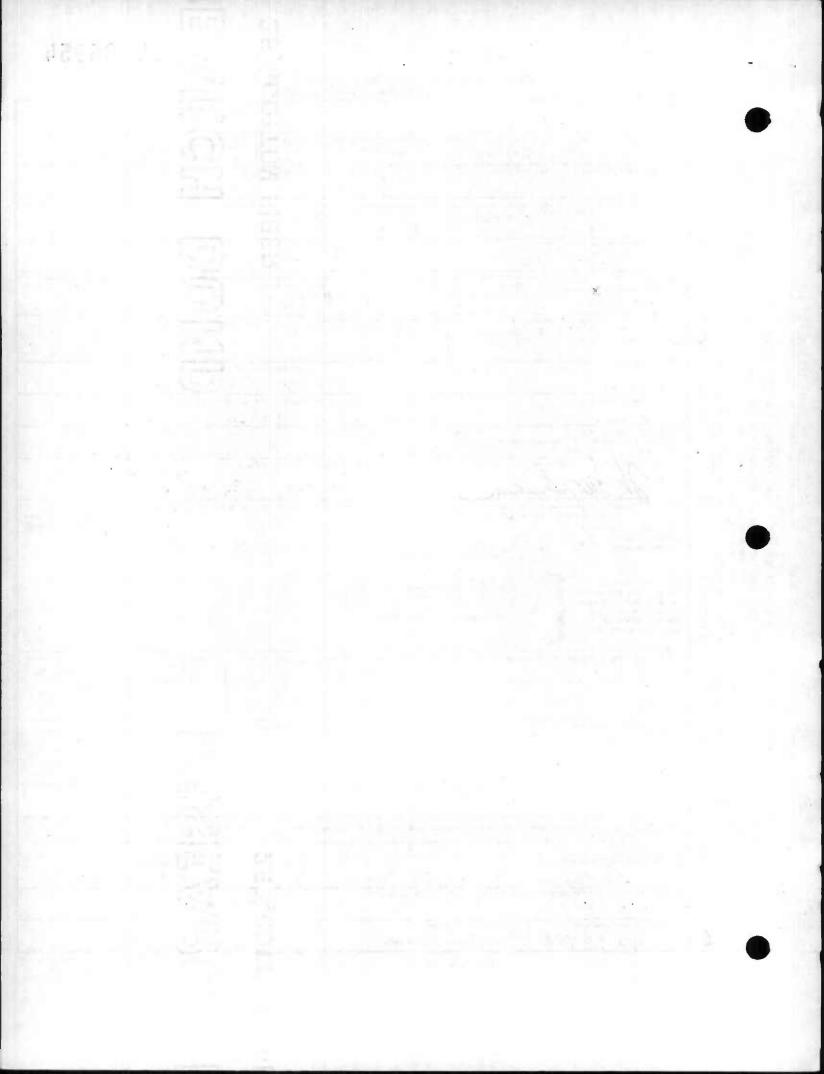
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TO THE HOSPITA	TO THE FUNERAL DIRECTOR: After this certificate has been sign
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	ils certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should		
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after dea	y the fur	noval.	and lan
Nours	lled in b), or ren	Spann a
YSICIAN: The law requires that the death certhicate be executed within Thours after death. Page 6 may be retained by the hospital or attending physicials.	pletely fil	the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	are the many and leaves any leaves to make the manifest and and an analysis at a contract of
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THE HOSPITAL DR ATTENDING PHY	FUNERAL DIRECTOR: After this	filed within 72 hours after death with	ADDODIANT: 16 14am 29 is marked
DR AL	DIRECT	hours a	Stares 2
OSPITAL	JNERAL	ithin 72	MT- 16
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l	STATE OF MARYLA		TMENT OF HEALTH CATE OF DEAT	ENTAL HYG	
ME (First, Middle, Last)		7.1	1	2. DATE OF DEAT	Н

	1 - STATE OF MARY	/LAND / DEPARTMENT OF CERTIFICATE C		NTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Howard		DATE OF DEATH MONTH DAY	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AG	E (In yrs. last birthday) IF UNDER 1 YEA	ST. R IF UNDER 24 HRS. 7.	DATE OF BIRTH	a. BIRTHPLACE (State or Foreign		
		98 YRS. MONTHS DAY		eb 26, 1936	Virginia		
DIRECTOR	9e. FACILITY NAME (If not institution, give street end number) Howard County General RESIDENCE OF DECEDENT		n or location of death lumbia		unty of death Howard		
JEC.	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LO	CATION		10d. INSIDE CITY		
	Maryland Howard 100. STREET AND NUMBER	Ellico	tt City		LIMITS? 1 YES 2 NO		
FUNERAL	9749 Riverside Circle		101. ZIP CODE 21042		nited States		
BY FUN	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1X YE IF YES, GIVE WAR DE	S 2 NO If yes	ECENDENT OF HISPANIC (specify Cuben, Maxican, P ES 2 NO Specify:	ORIGIN? (Specify Yes or No	14. RACE — American Indian, Black, White, etc. Specify: White		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEDENT'S USUAL OCCUP. (Give kind of work done during	TION most of working	16b. KIND OF BUSINESS/IN			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	Me. Do NOT use retired.) Truck Driver	most or working	Mountain S	ide Transport		
O M	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME ((First, Middle, Maiden Surname)			
BE	G. Russell Howard		Helene G	eorge			
2	190. INFORMANT'S NAME (Type/Print) Mrs. Gwen Howard			e Number, City or Town, State, Zi Ellicott City			
	1/E Buriel 2 Cremefion 3 Removal from State	20b. PLACE AND DATE OF DISPOSITION competery, crematory or other place)			- City or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		AND ADDRESS OF FACILIT	TY	ttsville, MD		
	Harry H. With	ne 411	2 Old Colum	Funeral Home bia Pike Elli	icott City21043		
	23. PART I. Enter the disease, or complications that cause ahock, or haprt/fallura. List only one common on	ed the death. Do not enter the	noda of dying, auch as	a cardiac or reapiretory ar	rraat, Approximate		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	S A CONSEQUENCE OF): S A CONSEQUENCE OF):	PIBRIL	LATION.	Onset and Daath		
z		S A CONSEQUENCE OF	= ANTER	IPR MALL			
OT	Sequentially list conditions, If any, leading to immediata cause. Enter UNDERLYING	S A CONSEQUENCE OF):	mysurp	DIAL IN	PARETION		
FIC	CAUSE (Disease or Injury C.	S A CONSEQUENCE OF):					
CERTIFICATION	resulting in daeth) LAST						
- 11	PART II. Other algnificent conditions contributing to deeth	but not resulting in the underly	ing causa given in Per	1 I. 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICAL				PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME	DID TORACCO LICE CONTRIBUTE TO CALICE	OF DEATH WES TIME		_	1 TYES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (Check only o					
YSIC	EXAMINER? 1 YES 3 NO HOSPITAL: 1 Inpetient 2 PRI/O	utpatient 3 DOA OTHER:	ome 5 - Residence 6 -	Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending 26. DATE OF INJUR (Month, Day, Year) INJURY	WORK?	d. OEŞCRIBE HOW INJURY OC	CURED		
2 Accident Investigation "Investigation "Investigation "Investigation "Investigation I							
3 Success 4 Momicide 4 Momicide 5 Could not be building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, dasth occurred at the time, date and place, end due to the cause(e) and manner as attend.							
MP	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knew one) 2 MEDICAL EXAMINER: On the best of exeminer						
	29b. SIGNATURE AND TITLE OF CERTIFIER	ton enable investigation, in my opinion	29c. LICENSE NUMBER		TE SIGNEO (Month, Day, Year)		
10 BE	beling It chroleur	1	10280	721	11/27194		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	ATH (ITEM 27) (Type, Print)	HT 4KAKY	RIDATRA	,		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIG	GNATURE		CONNERIO	mD 21044		
	NOV 2 9 1994 Juli Daw	dier Randall		712	- 2 4044		

		ME (First, Middle, Les		2774						2. DATE	OF DEATH			3. TIME OF DEAT
	Charl	les Barto	n Hull, S	SR						MONTH	DA	23 5	74 °	2:00
	4. SOCIAL SECURI		5. SEX	8. AGE (In yrs	s. lest birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE (OF BIRTH	8.	BIRTH	IPLACE (State or Fo
	204-22	-2927	1 🔀 M 2 🗌 F	71	YRS.	MONTHS	DAYS	HOURS	MIN.	6	18/23		Countr	PA
	9a. FACILITY NAME	(If not institution, give	street and number)			9b. CITY	TOWN O	R LOCATI	ON OF DE	ATH		9c. COUNTY	Y OF D	EATH
H	725 K	Celly RD				00	cean	Cit	У			Wo	rce	ester
5	RESIDENCE C	F DECEDENT												
DIRECTOR	10a. STATE MD	10b. COUN	Worces	ter		Y, TOWN								10d. INSIDE CITY
						Ocea	n Ci	ity						1 YES 2
FUNERAL	725 Ke	NUMBER RD					101.	ZIP CODE					US	MHAT COUNTRY?
5	11. MARITAL STATU	IS	12. WAS DECEDE	NT EYER IN U.S	. ARMED						? (Specify Yes	or No 14	. RACE	E — American India
BY F	1 Never Merried 3 Widowed 4			1 XYES 2 WAR OR DATES					n, Mexicar Specify	n, Puerto R	ican, etc.)			k, White, etc.
	5 Wildows													1
TED	(S ₄	15. DECEDENT'S EL pecify only highest gra		16a	Give kind of	work done	CCUPATIO	N st of workin	ng	16b.	KIND OF BUS	NESS/INDUS	TRY	
PLET	Elementary/Sec	ondary (0-12)	College (1-4 or 5	+)	life. Do NOT u									
M	6				Locks	smith					Secu	rity		
COM	17. FATHER'S NAME										liddle, Maiden			
BE	Hiram H									,	tta We			
0	19a. INFORMANT'S										er, City or Town		ode)	
	Betty F				725	Kell	y R	D O	cean	City	, MD	2184	12	
	20a. METHOO OF D	DISPOSITION Cremation 3 Re	movel from State	20b. PLA	CEANDDATE	OF DISPOS	ITION (Nar	me of	T cold	OATE	20c. LOC	CATION - CI	y or To	own, State
	4 Donation 5	Other (Specify)		Lor	raine	Park	Cer	mete	ry	11/	26 Ba	altimo	re,	MD
	21. SIGNATURE OF	UNERS SERVICE	LICENSEE			22.	NAME AN	D ADDRE	SS OF FAC	CILITY	Rurhac	re Fu	ner	al Home
	1 × 1/2	441/	whale				108	Will	iame		Berlin			21811
	I 23 PART I Ente	the diseases o	r complications th	ot coursed the	doub Do									
	ahoo	ck, or heert feilure	. Liet only one ca	use on each	line.	not enter	the mot	ue or uy	ing, sucr	a a celu	iec or reapi	A A	H.,	Approximation interval Be
	IMMEDIATE CAUSE (Finel													
	disease or condition resulting in death) a. Henoptysis + bleeding to death Due to (or as a consequence of):													
	DUE TO (OR AS A CONSEQUENCE OF):										00			1
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ICATION	If any, leading to cause. Enter UN	o immediate	b. DUE TO	O (OR AS A COM	MA C)	4m (ER		0	P				
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ERTIFICATION	if any, leading to cause. Enter UN CAUSE (Disease	o Immediate IDERLYING o or Injury ents	b. DUE TO	O (OR AS A COM	MA C)	4m (ER							
L CERTIFICATION	If any, leading to cause. Enter UN CAUSE (Disease that initiated ev- resulting in dea	o Immediate IDERLYING or Injury ents th) LAST	b. DUE TO	O (OR AS A COM	O C)	4m (ip: ip:	ER						1 246	WERE ALTYDRY EN
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CAL	If any, leading to cause. Enter UN CAUSE (Disease that initiated ev- resulting in dea	o Immediate IDERLYING or Injury ents th) LAST	b. DUE TO	O (OR AS A COM	O C)	4m (ip: ip:	ER				24a. WAS AN	AUTOPSY MEO?	24b	
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: MEDICAL	If any, leading to cause. Enter UN CAUSE (Disease that initiated excessiting in dea	o Immediate IDERLYING o or Injury ents th) LAST	b. DUE TO	O (OR AS A COM	O C)	4m (ip: ip:	ER				24a. WAS AN PERFORI	AUTOPSY MEO?	24b	AVAILABLE PRIOR
AN: MEDICAL	If any, leading to cause. Enter UN CAUSE (Disease that initiated excessiting in dea	o Immediate IDERLYING or Injury ents th) LAST	DUE TO DUE TO d. one contributing to	O (OR AS A COM	O C)	子介(序): in the ur	E R	l cense i	given in I		24a. WAS AN PERFORI	AUTOPSY MEO?	24b	AWAILABLE PRIOR COMPLETION OF
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Hospital Council of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG NO

		CERTIFI	CATE OF	DEATH	MENTAL	REG. NO.						
1. DECEDENT'S NAME (First, Middle, Last)			HANN	IN	2. DATE O			YEAR 3. TIME OF DEATH				
Lorraine Kat	thryn				7. DATE O	<u>45</u>	94	0213				
212-28-6113	MONTHS DAYS HOUSES MIN							BIRTHPLACE (Stote or Foreign Country) Maryland				
9s. FACILITY NAME (If not institution, give street end number) 9s. CITY, TOWN OR LOCATION OF DEATH 9s. CITY, TOWN OR LOCATION OF DEATH 9s. CITY, TOWN OR LOCATION OF DEATH												
PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO												
RESIDENCE OF DECEDENT												
MD Word	ester		TOWN OR LOCATI					10d. INSIDE CITY LIMITS?				
10e. STREET AND NUMBER	ester	1 00	ean City	ZIP CODE		1 100	CITIZEN OF I	1 XYES 2 NO				
14007 Sailing Roa	ad			1842		log.	USA					
11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECE	NDENT OF HISPAI		(Specify Yes or No	- 14. RAC	E — American Indian.				
1 Never Married 2 Merried	FORCES? 1 YES			city Cuban, Mexico 2 XNO Specif		cen, atc.)	Spec	k, White, atc.				
3 Widowed 4 Divorced								White				
15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of we	JSUAL OCCUPATION ork done during mos retired.)	N t of working	16b.	KIND OF BUSINESS	/industry					
Elementary/Secondary (0-12)	College (1-4 or 5+)	Housew			11.							
17. FATHER'S NAME (First, Middle, Last)		Housew	viie	18. MOTHER'S NA		omemake						
James O. Strigle				Agnes	_		,					
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street an			r, City or Town, State	, Zip Code)					
Thomas F. Hanne	on	14007	Sailing	Rd. Oc	ean (City, MD	2184	2				
Thomas F. Hannon 14007 Sailing Rd. Ocean City, MD 21842 20e. METHOD OF DISPOSITION DATE 20e. LOCATION — City or Town, State Cape Henlopen Crematory 11/26/94 Frankford, DE												
4 Donation 5 Other (Specify)	C	ape Hen	lopen Cı	rematory	y 111/2	2 6 /94 Fr	ankfo	rd. DE				
22. NAME AND ADDRESS OF FACILITY Burbace Funeral Home 108 Williams St.												
Burbage Funeral Home Berlin, MD 23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate												
immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, isading to immediate cause. Enter Underlying												
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burials		
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94 36956 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Alice Marie Hamilton 1994 a M ecember 10:45 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthdey) 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreig Country) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 1 🗌 M 2 💢 F 70 218-14-3259 June 29, 1924 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9h CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1785 Margaret Ave Bryans Road Charles 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Charles Bryans Road 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 1785 Margaret Ave 20616 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE - American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY Specify: 3 🕅 Widowed 4 🗌 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) 11 Homemaker Her Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) John Hillary Quade BE Mary Leasie Owens 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Wood Rt. 1, Box 401, White Plains, Md. 20695 20g-METNOD OF DISPOSITION
1 2 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE emetery, cremetery or other place)
Trinity Memorial Gardens 12-5-94 Waldorf, Maryland 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Nist M00668 M00668

Rt. 225 & Clymont Rd. Indian Head.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiec or respiratory errest, | Appl. Md 20640 shock or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE IFINAL Onset and Death disesse or condition DIE TO (OR AS, A CONSEQUENCE OF) resulting in dasth) PHYSICIAN: MEDICAL CERTIFICATION Sequantisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesae or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART ii. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: Residence 8 C Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netural
2 Accident 5 Pending 1 YES 2 NO Bγ 3 Suicide 28a. PLACE OF INJURY - At he building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide determined 29a. CERTIFIER (Check only one) dge, death occurred at the time, data and place, and due to the cause(a) and manner as stated

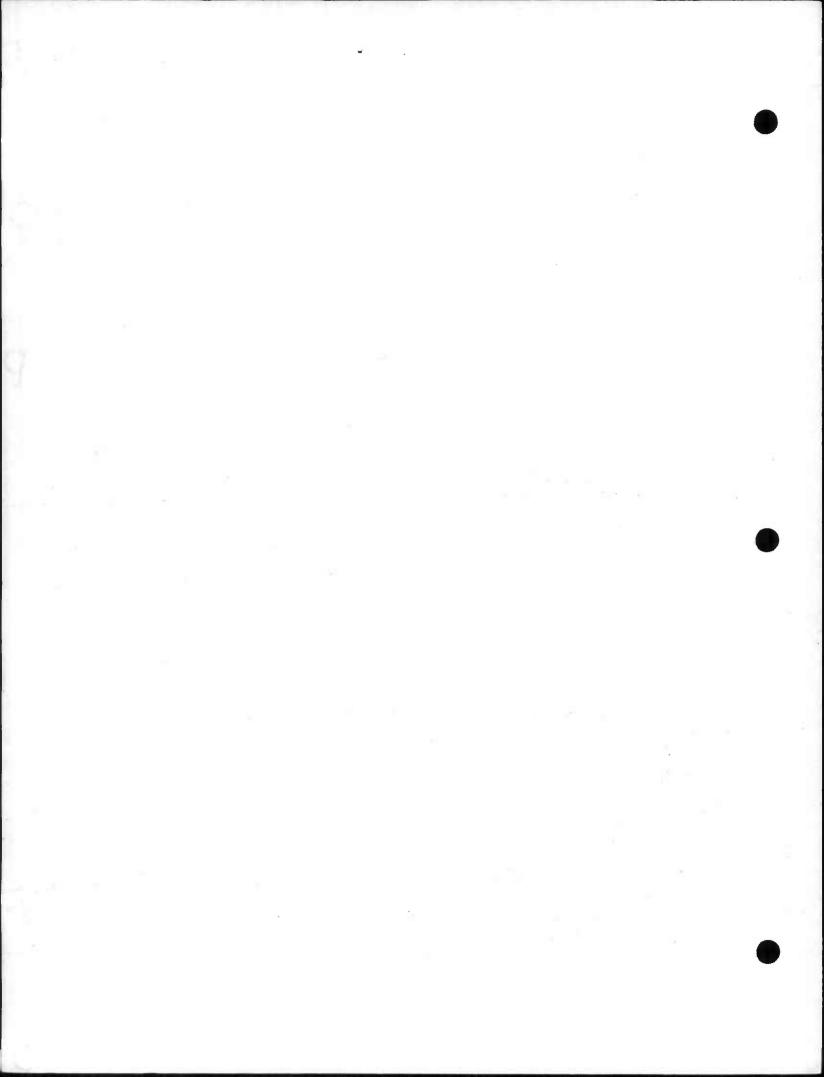
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

206. SIGNATURE AND TITLE OF CERT)FIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)
DEC 0 5

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		1 - STATE REGISTRAR	STATE OF MAR			MENT OF H		MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle	lle, Lasi)					2. DATE OF DEATH		3. TIME OF DEAT	'N		
	1		A. James Hal					November		994 7:27 p	m m		
Pe	4	4. SOCIAL SECURITY NUMBER 053–26–8936	1 🔀 M 2 🗆 F	NGE (In yrs. las		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH DCT 18, Year 1	32	Country Canada	reign		
3 should	Œ	9a. FACILITY NAME (If not institutio			1		R LOCATION OF D	EATN		Y OF DEATN			
2,	CTOR	11205 Landy	ENT			Ken	sington		1 1	Montgomery			
it. Pages	DIRE		lontgomery			ington		10d. INSIDE CITY LIMITS? YES 2 \(\text{NO} \) NO					
215-0020 attending physician. se as the burial-transit permit. Pages 1,	FUNERAL	100. STREET AND NUMBER 11205 Landy Co	ourt				. ZIP CODE 0895		10g. CITIZE USA	N OF WHAT COUNTRY?			
	B₹	11. MARITAL STATUS 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. WAS DECEDENT EVEN FORCES? 1 V V V V V V V V V V V V V V V V V V	12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HIS If yes, specify Cuban, Ma 1 YES 2 NO So				in, Puarto Rican, etc.)	4. RACE — American India Black, White, atc. Specify: White	ın,			
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A de de	ш	17. FATHER'S NAME (First, Middle, L A. James Ha				ME (First, Middle, Maiden e (Towner)	Surname)						
be retained by ge 5 should be notified at	TO B	190. INFORMANT'S NAME (Typo/Pri Sharon E. McFi	,					Acute Number, City or Townsington, M					
		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	☐ Removal from State	20b. PLACE	NDDATEOF	DISPOSITION (National Communication Communic	me of	OATE 20c. LC		nd, MD			
ALTIM death. Page funeral direc		21. SIGNATURE OF FUNERAL SER		1							-		
BALTIMOR after death. Page 6 may the funeral director, proval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SCATPEIL Funeral Home Cumberland, MD 21502 23. PART . Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
within hours within hours pletely filled in cremation, or re rent, the med		23. PART / Enter the disease ahock, or heart fi iMMEDIATE CAUSE (Final disease or condition resulting in death)	es, or complications that calvalations. List only ona cause of Brain Tu	umor (Gliom		da of dying, auc	h as cardiac or resp	fretory arres	Approximatintarval Ballonset and 1½ yea	tween Death		
P.O. BOX 68: n certificate be execute anding physician and of Hygiene prior to buria or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF): d												
CORDS uires that the signed by the Health and Me ws any Inju	EDICAL	PART ii. Other significant co	onditions contributing to deat	th but not ra	aaulting in	the underlying	cause givan in	Part i. 24s. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FIN AWAILABLE PRIOR 1 COMPLETION OF COOF OF OF OF OF OF OF OF OF OF OF OF OF	TO AUSE		
L RE law request as been Dept. of 23 sho	N.	DID TOBACCO USE C	CONTRIBUTE TO CAUSE	OF DEA	TH YES		UNCERTAIL	<u> </u>		1 123 2 20 14	°		
/ITAI	PHYSICIAN:	25. WAS CASE REFERRED TO MED EXAMINER?	HOSPITAL:		To	(Check only one)							
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ON OI DING PHYS After this death with	ВУ Р	1 Neturel 5 Pendin		er)	INJUR		RK? ES 2 NO						
ISIC TTENDI TTOR: A after de 28 is		3 Suicide 8 Could 4 Nomicide determ		URY — At hor (Specify)	me, farm, stre	et, factory, office		281. LOCATION (Street City or Town, State)	end Number or	Rural Route Number,			
국 국 =	COMPLETED		G PHYSICIAN: To the best of my ki								sted.		
TO THE HOSPIT TO THE FUNERA DE filed within 7	O BE	29b. SIGNATURE AND TITLE OF CE	Houll		NI)		29c. LICENSE NUI D04766			ember 26,19	994		
		30. NAME AND ADDRESS OF PERS	lum, M.D. 104	•		•	enue, Ke	nsington,	MD 20	0895	\neg		
		31. DATE FILEO (MODID POY YEAR)	32. REGISTRAR'S S										
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF															
	ď	Patricia		la HONA								MONTH	DEATH	AY	MO YEAR	3. TIME OF BEATH
		4. SOCIAL SECURITY NUMB	5. SEX	6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					1100		4,1	794	16.30 "			
	,	220-28-7883		1 M 2 X F	W ONDER ! I EAR			T -	HOURS	MIN.	7. DATE OF (Month,)	BIRTH	2/	6. BIRT	HPLACE (State or Foreign Try) LYLAND	
	į	9a. FACILITY NAME (If not in:	ada ata a ata a			00	THO.									
					D			96. CIT	Y, TOWN	OR LOCAT				9c. CO	UNTY OF D	
] [2	Washington 1		nospera	<u> </u>	Hagerstown) LON	on Washington				
ū	3	10e. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d, INSIDE CITY					
DIBERTOB	5	Md.		Washing	ton				Hage	ersto	own					LIMITS? 1 YES 2 X NO
	- 11	10e. STREET AND NUMBER							10	1. ZIP. COD)E			10a, Cl	TIZEN OF	WHAT COUNTRY?
â		17544 Woodle	awn Dr						21	1740					S.A	
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		1 Never Married 2 Married FORCES? t Y IF YES, GIVE WAR OF				S 2 X NO If yes, specify Cuben, Maxican,				n, Puerto Ric	en, etc.)		Blac	k, White, atc.		
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COMPI FTED	3	17. FATHER'S NAME (First, MI								18, MOT	HER'S NA	ME (First, Mid	dle, Maiden	Sumame)		
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T left		19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Aural Route Number, City or Town, State, Zip Code)												1		
90		Jackie L. Kephart 600 Linganore Ave. Hagerstown, Md. 21740														
nst		20s. METHOD OF DISPOSITION 1 Burlist 2 (Cremation 3 Ramoval from State Ageneral Figure 1 Cremation 3 Ramoval from State Ageneral Figure 1 Cremation 3 Ramoval from State Ageneral Figure 1 Cremation 1														
E		4 □ Donatton = □ Other (Specify) Smithsburg Chematory 12-1-94 Smithsburg, Ma.														
틭		Davis Eunetal Home 12525 Bradbury Ave.														
exa		Smithsburg, Md. 21783														
dica		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, Approximate														
Ē	ı	shock, or heart fellure. Liet only one ceuse on each line. Interval Between Onset and Death														
Ě		disease or condition equilibrium of the control of														
ows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COM	į	recording in death)		DUE TO	(OR AS A	CONSEC	UENCE O	F):								
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ry, or other traumatic		Sequentially list condition if any, leading to immediate		DUE TO	(OR AS A	CONSEC	UENCE O	F):				8	acem	cke	leal	
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ed, or Item PHYSICIA		EXAMINER?		HOSPITAL:			T	OTHE	R:	10_3		-10				
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		2 L MEDIC	AL EXAMINE	H: On the basis of e	remination	n and/or li	nveatigatio	n, In my c	pinion, d	eath occur	red at the	time, data an	d place, an	d dua to t	he cause(s	s) and menner as stated.
MPORTANT: If Item O BE COMPLE		296, SIGNATURE AND TUTLE	OF CENTIFIER	1						29c. LICI	ENSE NUN	19ER		29d. DA	TE SIGNED	(Month, Day, Year)
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If then 28 is marked or them 23 shows any initivy or other formatic event the medical examiner must be notified at more
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	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIE						
	1. DECEDENT'S NAME (First, Middle, Last) GERALD H		J	ohnso	2. DATE OF DEATH MONTH DECEM	DAY 2	1994	3. TIME OF DEA	ATH A M			
		8. AGE	E (In yrs. lest birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) NOV . 11, 1		6. BIRTH	NPLACE (Stote or I			
OR	90. FACILITY NAME (If not institution, give street Shady Grove Advent		al		R LOCATION OF DI		9c. CO	UNTY OF D		U do de à RC		
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			Y. TOWN OR LOCAL			4	201106	10d. INSIDE CIT	-		
FUNERAL DIRECTOR	Maryland Montg	gomery		Dam	ascus				LIMITS?	XNO		
ERA	27604 Ridge Roa	d		101	20872				States			
ВУ		2. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 TNO	It yes, sp	ENDENT OF HISPAN	NIC ORIGIN? (Specify on, Puerto Rican, etc.)			E — American Ind k, White, etc.	llen,		
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	mpleted)	16e. DECEDENT'S (Give kind of v	USUAL OCCUPATION CONTROL OCCUPAT	IN st of working	16b. KIND OF E	USINESS/IN	IDUSTRY	HILL GE			
IPL.	8	College (1-4 or 5+)		enter		Priv	ate I	ndust	trv			
CON	17. FATNER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Maid		Industry ame)				
BE	William Alle	n Johnson		- 31		a Myrtle						
10	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27604 Ridge Road, Damascus, Md. 20872											
	20s. METNOD OF DISPOSITION 1 Duriet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetary or other place)											
	Montgomery Meth. Cem. 12/5/91 Damascus, Md											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY OLIN L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872											
	23 PART I Enter the diseases or com	oleswa	ur	2640	l Ridge	Rd., Dama	scus	, Md.				
	shock, or heart fellure. List only one cause on each line.									nate Batwean Id Daath		
	resulting in death) a	DUE TO (OR AS	A CONSEQUENCE DE	onet and Onet and Onet and SS								
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IFIC	CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS	A CONSEQUENCE OF	J W	01	1 oute	22	0	10	4		
CERT	resulting in death) LAST	Chom	i Olist	nuclir	Puls	money	Ide.	rey	, ,			
MEDICAL	PART II. Other significant conditions of	ontributing to death	but/not resulting i	n the underlying	cause given in		N AUTOPSY	24b	. WERE AUTOPSY F AVAILABLE PRIOF	R TO		
Ē	Planar Ela	ming i	Thomas	0, 101	anno	YES	2 NO		COMPLETION OF DF DEATN?	CAUSE		
	DID TOBACCO USE CONTRIB	LITE TO CAUSE (DE DEATH VE	S IZI NO [UNCERTAIN				1 YES 2	NO		
AN	25. WAS CASE REFERRED TO MEDICAL	OIL TO CAUSE (26. PLACE OF DEAT	<u> </u>	UNCERIAII	<u>ч </u>						
Sic	EXAMINER? 1 YES 2 NO 1	OSPITAL: Inpatient 2 - ER/Out	tpatient 3 DOA	OTHER:	5 Residence	6 Other (Specify)						
PHYSICIAN:	27. MANNER OF DEATN 1. Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)			JRY AT	28d. DESCRIBE NOW	INJURY O	CCURED				
В	2 Accident Investigation	20- 81 405 05 10 110	N 444		E\$ 2 NO							
ETED	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJUR building, etc. (Spe	ecify)	treet, factory, office		281. LOCATION (Stree City or Town, Star	t end Numbe e)	er or Rural F	loute Number,			
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN ONE) 2 MEDICAL EXAMINER: 0	N: To the best of my known the best of examination							e) end manner ee	stated.		
BE	29b. SIGNATURE AND TYPE OF CENTIFIED	2111	1	110	29c. LICENSE NUM		29d. DA	TE SIGNED	(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF D	EATN (ITEM 27) (Type,	1	0 10	4.20.0			142)1	007		
	31. DATE FILED (Monty), Day, Year)	32. REGISTRAR'S SIGN	Paulson Ra	- 14	dawa sa	us MD 2	087	2				
	DEC 0 5 19	74	The Mariner Ma	rotall								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH	
ECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH
13131.0	D JOHNSON	NONTH PED PAY

	1 - STATE REGISTRAR SIAIE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.													
	1. DECEDENT'S NAME (First, Middle, Last)								2 DATE OF	DEATH		VEAD	3. TIME OF DEATH	
	ANNA		D	5				NÖVEMBER 27,				07:30AM	M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday) YRS.	MONTHS			24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)			Count		
	214-82-7971 9a. FACILITY NAME (If not institution, give si		- 54	L YHS.	01 OIT	70481.0	R LOCATIO		Feb.	15,	1940 Maryland			_
E				77				АТН		2011				
5	NORTH ARUNDEL HO					EN B	URNI	-			1 A.F	4. CO	UNIY	\exists
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT		OR LOCAT							10d. INSIDE CITY LIMITS?	
	Maryland Ann 100. STREET AND NUMBER	<u>ne Arunde</u>	1		G:		ZIP CODE			1 TYES ZONO	4			
FUNERAL	7995 Nola Park				101.	2106				_	SA	WHAT COUNTRY?		
S	11. MARITAL STATUS	T EVER IN U.S. ARM						IC ORIGIN? (S		or No—	14. RACI	E — American Indian,	Н	
ВУ Б	1 Never Married 2x Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 NO			cify Cubar 2 XNO		n, Puarto Rica	n, atc.)			Black, White, etc. Specify: Black		
	15. DECEDENT'S EDUC	CATION	18a, DEC	18a. DECEDENT'S USUAL OCCUPATION					16h KI	D OF BUS	CINEGO /IM	DUCTOV		4
E	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	(Giv	e kind of t	work done se retired.)	during mos	t of workin	0	100. Kir	ND OF BOS	JINESS/IN	DOSTAT		
COMPLETED	5			Dor	nest:	ic								
	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAM	ME (First, Midd			4.1		\neg
BE	Unknown 19a. INFORMANT'S NAME (Type/Print)		100				272	Sec.	Ethe1		Po			4
2	Helen Durant		59	10 6	60th	Ave.	nd Number Ri		lale,			(p Code)		
	208. METHOD OF DISPOSITION		20b. PLACE AI	ND DATE	OF DISPOS	SITION / Na	ne of		DATE		- :	City or To	own, Stata	\dashv
	1 X Burial 2 Cremation 3 Rame 4 Donetion 5 Other (Specify)		Carro	etory or o						Pr	ince	Free	derick, MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE							Se'					
	spencer	, E. Sa	well	5									i.,MD 20678	}
	23. PART I. Enter the diseases, Dr o ahock, or heart fellure. I	omplications that List only one cau	t caused the dea	th. Do r	not antar	tha mod	da of dyle	ng, such	as cardiac	or raapi	ratory ar	reat,	Approximate Interval Between	
	ahock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition										Onset and Deat			
	resulting in death)	DUE TO	IOM-AS A CONSECU	JENCE OF	K	w	College dell of hours						4	
z	-	Cong	estue	2/	ear	7	ta	ele	ure		Po	N. V	Par	
CERTIFICATION	Sequantisity list conditions, if any, leading to immediate	DUE	OR AS A CONSEQU	HINCE OF	F):	1	-6	1		-1	0	2	1 0	7
2	CAUSE (Disesse or injury	. COU	ice 1	COL	we	zell	2	00	ele	tex	de	we	1 days	_
Ē	that initiated events resulting in death) LAST	. Al.	elles	Ri	1. //	MI	111	o l	Du	a_			mule	1
	DART II. Orbita significant ask distan	11/4	- F				1							
ICAL	PART II Other significant condition	ii contributing to	daath but not re	auiting	In the ur	ndarlying	¢ause g	Ivan in F	Part I. 24	PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	4
MEDI	Liesure	DIS	arde	del					- 1	YES 2	Ø-HO		OF DEATH?	1
2 7	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEAT	H YE	s 🗆 i	№ П	UNC	ERTAIN					1 YES 2 NO	-1
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE		TH (Check	only one)								
YSI	1 🗆 YES 2 🗇 AO		ER/Outpatient 3	DOA	4 Nur		5 🗆 Re	eldenca 8	8 Other (Sp	pecify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, Da		28b, TIM INJ	E OF URY	28c. INJU WOI	RK?		28d. DESCRI	BE HOW IF	NJURY OC	CURED		
B	2 Accident Investigation	28a, PLACE O	F INJURY — At hom	o form	tract fact		ES 2 _	-	28I. LOCATIO	M /Ctd -	and Mountain	0 / /	2 M	4
回	4 Homicide 8 Could not be determined		atc. (Specify)	,		ory, orrica				wn, State)	ino reanioe	r or norm r	noute Namber,	1
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, deal	th occurr	ed at the t	lme, date	and place.	and due t	to the cause/s	and man	oper an ete	ted =		۲
OM	one) 2 MEDICAL EXAMINE) and menner as stated.	1
w II	296 MONATURE AND TITL DATE GERTISTER	1-011	/				29c LICE	NSE NUM	BER) =	>	29d. DAT	E SIGNED	Mongo Dunfanas,	┥
10 B	1//2	free (\supset				0	タレ	18)	1	1/0	7/94	
	30. NAME AND ADDRESS OF PERSON WHO		-								8 -	/	. /	7
	ANASTACIO E SUBO	32, REGISTRA	/206 CRA		IGHW	AY S	W/ <u>G</u>	EN	BURNIE	. MA	RYLA	ND 2	1061	4
	DEC 1 1994	Jan Bau	vileon-Randa	Ц										

THE REP. 1. 100 E.

		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL	HYGIENE REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)	lafr	T. P.	Son		2. DATE O MONTH		9 Z	AR	: 20	
pino		4. SOCIAL SECURITY NUMBER 218143753 9e. FACILITY NAME (If not institution, give st	5. SEX 6. AGE (n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE	7. DATE OF (Month)	BIRTH Day, Year)	22	BIRTHPLAC Country) Mary1	E (State or F	
2, 3 should	lon BO	Calvert Memor		al		e Frede		,	county Ca]	lver	t	
Pages 1,	DIRECTOR	PRESIDENCE OF DECEDENT 10e. STATE MD. Co	1		Y, TOWN OR LOCAT	TION				10d.	INSIDE CIT	Y
permit. F	AL D	10e. STREET AND NUMBER	alvert		Lusby,	. ZIP CODE		10	g. CITIZEN		YES 2 (2)	
ian. transit	FUNER	11725 Mill Bridg	e Rd.	III S ADMED	142 WHS OFG	20657			USA			
215-0020 attending physician. use as the bunat-transit	BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 TNO	If yes, sp	ENDENT OF HISPAI ecify Cuban, Mexice 2 XNO Specif	m, Puerto Ric		No- 14.	Black, Wht	merican ind ite, etc. Black	
	ETED	15. DECEDENT'S EDUC (Specify only highest grade Elamentary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	18a. DECEDENT'S (Give kind of a life. Do NOT us	USUAL OCCUPATION work done during most retired.)	ON st of working	16b. K	IND OF BUSINE	SS/INDUST	RY		
ND hospit ached	COMPL	2	Conege (1-4 (if 5+)	Lat	orer							
by the	ш	17. FATHER'S NAME (First, Middle, Last) Thomas	Jefferson	1		16. MOTHER'S NA Anni		idle, Malden Sun		illip	S	
ay be retained page 5 should be notitied	TO B	190. INFORMANT'S NAME (Type/Print) Emily Bishop				idge Roa		City or Town, S Lusby,				
Page 6 may al director, pa		26e. METHOD OF DISPOSITION 1 4 Burlet 2 Cremetion 3 Remo 4 Donetton 5 Other (Specify)		PLACE AND DATE	OF DISPOSITION (Na ther place)		3/94	20c. LOCAT	oy, MI		tate	
SALT r death. e funera al. examil		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE Some	•		Dares Be)678
executed within E-hours after and completely filled in by the oburial, cremation, or removinatic event, the medical	NO	23. PART I. Enter the diseases, or conshock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	Paretan	de of dying, suc	h se cardis	c or reapirate	ry screst,		Approxim interval E Onset sn	Between
P.O. BOX th certificate be ending physician I Hygiene prior to or other traus	CERTIFICATION	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):							
L KECORDS, law requires that the deal as been signed by the att lept. of Health and Menta 23 shows any Injury,	MEDICAL	PART II. Other significant conditions 1, a betts a sthm a	ellitus				_	4a. WAS AN AUT PERFORME YES 2	07	COMI OF D	E AUTOPSY F ABLE PRIOR PLETION OF EATH? YES 2	CAUSE
has b Dept.	PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE	TH (Check only one)	UNCERTAII	N []					
SICIAN: The State the State	HYSIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Output 28e. DATE OF INJURY	etient 3 DOA		e 5 Residence			m. 0001101			
ON OF DING PHYSIC After this ce death with the	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	URY WO	RK? YES 2 NO	28d. DESCI	ULNI WOH 38IF	RY OCCUME	±D		
TOR: A after da after da 18	G	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Speci	— At home, term, s	street, fectory, office		261. LOCAT City or	ION (Street and I Town, Stete)	Vumber or R	tural Route f	lumber,	
보기사는	COMPLET		IAN: To the best of my knowler t: On the basis of exemination							use(s) end	manner es i	stated.
TO THE FUNER. TO THE FUNER, De filed within 7	BE	29b, SIGNATURE AND TITLE OF CERTIFIER	my			D4/2	SI4	29	d. DATE SIG	SNED (Mont	h, Day, Year)	
	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)		. [1/1.	~-	1	
Ψ		Paul Pomall 31. DATE FILED (Month, Dey, Year) DEC 2 1994	32. REGISTRAR'S SIGN	ATURE AVAIL		·						

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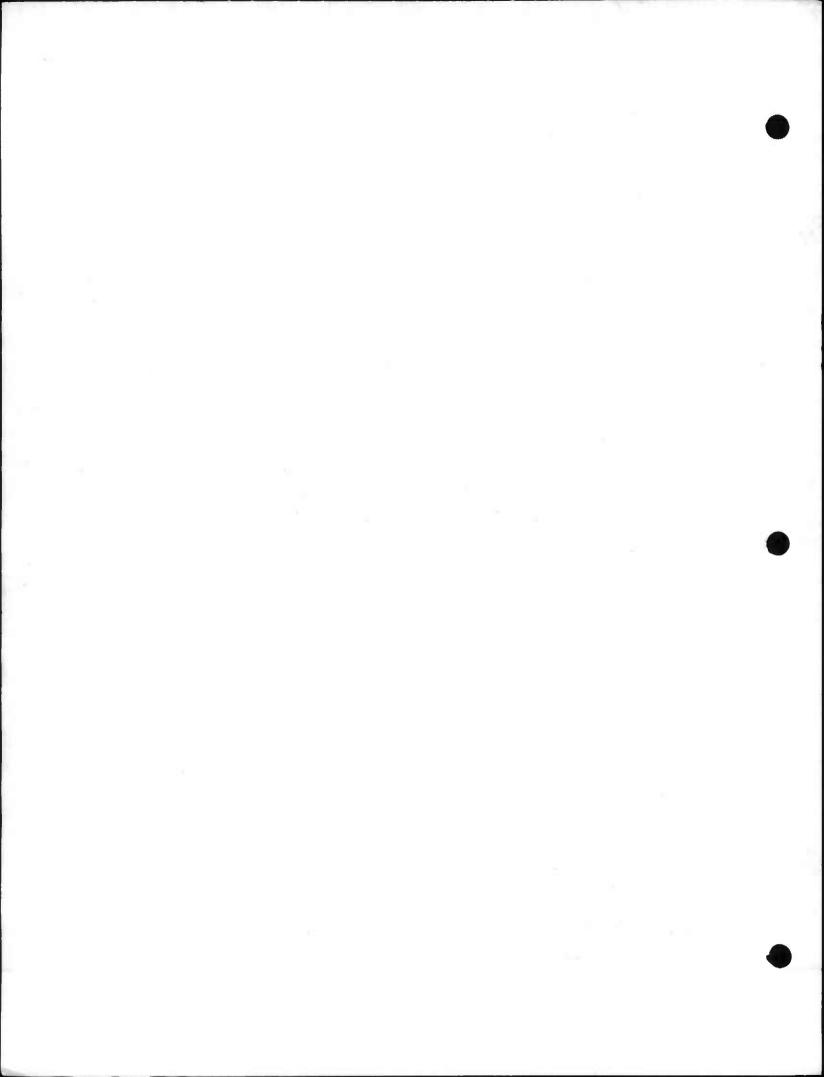
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funeral director, page 5 should be

4	dea	5	2
BAI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after dea	TO THE FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furning the filled within 72 hours after death with the State Dent of Health and Mental Hunlane Index to hurtal evanuation or second	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exa
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	h ce	House	0
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3 DAY 3. TIME OF DEATH RUTH VIRGINIA LANE JOHNS 1994 DE'C 11:55A.M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Morith, Day, Year)
OCT . 12-09 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 216-24-8565=A 1 IN XXX DAYS HOURS 85 MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOME+ 610 AMERICANIA DR. #203 DIRECTOR ANNAPOLISM D. ANNE ARUNDEL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? ANNE ARUNDEL ANNAPOLIS MD TYPES 2 | NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 610 AMERICANIA DRIVE APT. 203 U.S.A. 21403 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No-If yes, specify, Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 Z.Z.No. Specify: 14. RACE — American Indian, FORCES? 1 YES 2 NO 1 Never Married 2 North d BY 3 Widowed 4 Divorced AFRO AMERICAN COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) LABORER-RETIRED U.S.NAVAL ACAD. LAUNDRY ??? once. 17. FATHER'S NAME (First, Middle, Last)
ANDREW LANE 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 SUSIE TOOGOOD BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 KENDALL JOHNS SAME AS 10 90 20a, METHOD OF DISPOSITION
1 V Furlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must CEM. DEC.09+94 ANNAPOLIS, MD. 214011 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 2. VANE AND ADDRESS OF FACILITY ANNAPOLIS, MD. 21401 HOUSE OF HICKS 1922 FOREST DRIVE CHARLES E. HICKS 11 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, Approximate ehock, or heart failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final metastatic Oppet and Death the disease or condition CANCEL. Immthes resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditiona, DUE TO (OR AS A CONSEQUENCE OF)-If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in desth) LAST 9 any injury, PART II. Other significent conditions contributing to deeth but not recuiting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 | NO 1 X YES 2 | NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 Residence 6 □ Other (Specify) 1 TES 2 NO 1 Inpetient 2 ER/Outpetient 3 ID DOA a to 26s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH marked, 26b, TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Netural Accident 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) ETED. 3 Suicide 6 Could not be 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide COMPL 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as attained. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the lime, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER ronn Walsa 2386 12-9 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 32 JEGISTRAR'S SIGNATURE



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

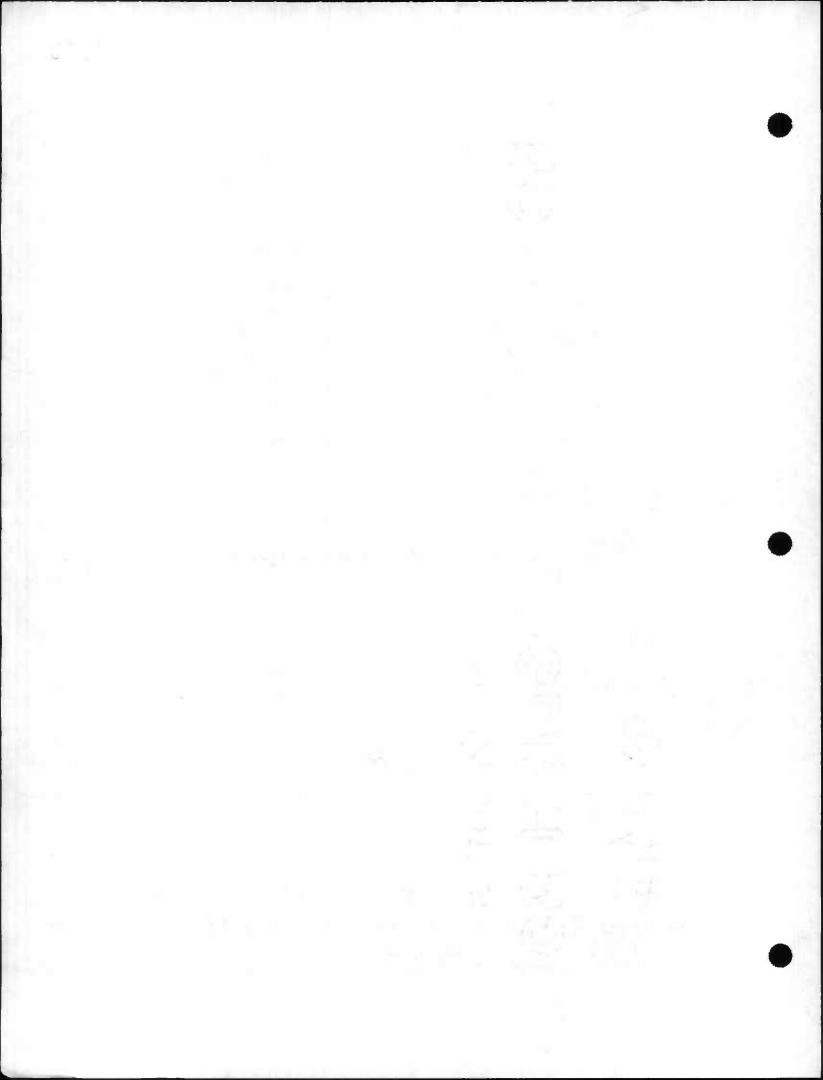
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE	0F	MARYLA	ND /	DEPARTMI	ENT OF	HEALTH	AND	MENTAL	HYGIENE
			CE	RTIFICA	TE C	F DEA	TH		REG. NO.

1 - FOR STATE REGISTRAR		STATE OF MA		/ DEPART				MENTA	L HYGIEN REG. NO.	E		
1. OECEDENT'S NAME (First, M	fiddle, Last)							2. DATE	OF DEATH			3. TIME OF DEATH
Lau	ıra De	elaney d	Jones					11	" 29 ["]	199	4	2:55 A M
4. SOCIAL SECURITY NUMBER	R	5. SEX 6	. AGE (In yrs. I		IF UNDER 1	_	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.		LACE (State or Foreign
214-74-9833		1 M 2 K F	94	YRS.	MONTHS	DAYS	HOURS MIN.		24,	1900		diana
9a. FACILITY NAME (If not insti	itution, give stre	et and number)			9b. CITY,	TOWN OF	LOCATION OF O			9c. COUNT		
Villa Rosa	Nursin	g Home			Mi	itch	ellville	9		Prin	ce G	George's
	10b. COUNTY			10c. CITY	, TOWN OF	R LOCATIO	ON				1	10d. INSIDE CITY
Maryland	Mont	gomery		1	Bethe	esda					1	LIMITS?
10e. STREET AND NUMBER		. y = 1 = _ <u>y</u>	-				ZIP CODE			10g. CITIZE	_	AT COUNTRY?
6002 Corew	r T boo	200					20816			Tinit	- A C	States
11. MARITAL STATUS		12. WAS DECEDENT	EVER IN U.S. /	ARMED	13. W	_	NOENT OF HISPA	NIC ORIGI	N? (Specify Yes			
1 Never Married 2 M		FORCES? 1 [YES 2 K	DND	10	yes, spec	cify Cuban, Mexic	en, Puerto			Black, Specify:	- American Indian, White, etc.
3 Widowed 4 Divorc	ed	ir its, dive we	ON DAILS			U 163	E M NO Speci	ıy.			эрвину.	White
15. DECE	DENT'S EDUCA	TION	16a. S	DECEOENT'S	USUAL OC	CUPATION	١	166	b. KIND OF BUS	SINESS/INDUS	STRY	***************************************
Elementary/Secondary (0-1)	highest grade c	College (1-4 or 5+)	- 1	(Give kind of with Do NOT us	onk done d retired.)	lunng mos	or working					
12				Hor	nemak	ker			Own	Home		
17. FATHER'S NAME (First, Mide	dle, Last)						16. MOTHER'S N.	AME (First,	Middle, Maiden	Sumame)		
William Pa	trick	Delanev					Clara	a Lat	ier			
19a. INFORMANT'S NAME (Typ				19b. MAILING	ADDRESS	(Street an	d Number or Rural			n, State, Zip C	ode)	
Laura J. Cai	ro			6002 (Corev	hoos	Lane,	Rethe	A sha	farv1a	nd	20816
204, METHOD OF DISPOSITIO	M									CATION - CH	_	
1 Burial 2 Cremation 4 Donation 5 Other (S		val from State	of cemeta	ry, crematory	or other pla	ace)De	C. 6, 19 L Cemete	94	7 2 1	ingto	n 17	'irginia
21. SIGNATURE OF FUNERAL		NSEE	M00				ADDRESS OF F					
Barbaro	Som	Emullo,		ience	Be	ethe: venue	sda-Cher e, Beth	vy Ch	nase,] Mary]	inc. 7	557 0814	Wisconsin 1-3501
23. PART I. Enter the dis												Approximate
ahock, or hed		ist only one ceus	e on eech il	ne.								Interval Between Onset and Death
disease or condition		MA	VALUE	CON	NO	10117	Mis	1 ml	1			1.166
resulting in death)		DUE TO (OR AS A CONS			KIVV	1113	0100				913
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Sequentially list condition			OR AS A CONS	EQUENCE OF	7:							1
If any, leading to immedicause. Enter UNDERLYIN	IG											
CAUSE (Disease or injury that initiated events	,) .	OUE TO (R AS A CONS	EQUENCE OF	7:							†
resulting in deeth) LAST												
	0.		^									
PART II. Other eignificen				t resulting I	n the un	derlying	cause given in	Part I.	24a. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Chris	- N	lut -	- Ker						1 TYES	V 100		COMPLETION OF CAUSE OF DEATH?
												1 - YES 2 ND
25. WAS CASE REFERRED TO						26. PL	ACE OF DEATH (C	heck only o	one)			
1 YES 2 NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	STHER	R: Na Home	5 🗆 Residence	6 🗆 Oth	er (Specify)			
27. MANNER OF DEATH		28e. DATE OF I	NJURY	28b, TIM	E OF	28c. INJU	JRY AT	T	SCRIBE HOW	INJURY OCCU	PRED	
1 Natural 5 P		(Month, Day	(Year)	INJ	URY	1 TY	RK7 ES 2 NO					
2 Cutatta	rventigation	28e. PLACE OF	INJURY — AI	home, ferm, r	street, facto	ory, office		28f. LO	CATION (Street	and Number o	r Aural Ac	oute Number
	Could not be elermined	building, a	tc. (Specify)		•	,,			y or Town, State,			
29a. CERTIFIER		1										
(Check only		IAN To the best of r										
MEDIC	AL EXAMINER	On the basis of exi	mination and/	or investigation	n, in my o	pinion, de	eath occured at th	e time, de	te and place, a	nd due to the	cause(a)	and manner as stated.
296. SIGNATURE AND TITLE	OF CONTIFIER	1,					29c. LICENSE N	JMBER		29d. DATE	SIGNED ((Month, Day, Year)
		cun	3	mg			03 22	61		D 11	-20	7-84
30. NAME AND ADDRESS OF	PERSONWHO	COMPLETEO CAUS	E DF OEATH (I	TEM 27) (Type,	Print)							
Richams	21	Follow	mm	0	1500	A	MAPUL	is	M	WAY	ムシ	n m
31. DATE FILED (Month, Day, Y		32. REGISTRAF	M	1		¥ ,						
DEC 0) 1 199	14 giona	Laurdson	-Hands	BC_							



Pages 1, 2, 3 should

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detached for use as the burial-transit hospital or attending physician. 8 phone page 5 s director, filled in by the or removal. cremation, and completely fi 2 the attending physician Mental Hygiene prior to and and Signed Health a been . has be Dept. certificate h this c DIRECTOR: After thours after death OR ATTENDING after . FUNERAL | within 72 h HOSPITAL

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994 SOPHONIE JOSEPH NOV 4:50 AM 5. SEX A SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 🗌 M 2 📈 F YRS. 8 NONE NOV. HAITI 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NIH, THE CLINICAL CENTER NIH. BETHESDA MONTGOMERY 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY HAITI NONE DANMARIE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? DETITE RIVIER 24 HAITI 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced BLACK COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 186. KIND OF BUSINESS/INDUSTRY (Specify only hig stary/Secondary (0-12) College (1-4 or 5 +) 4 STUDENT SCHOOL once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ ROOSEVELT JOSEPH MIMOSE DELCY BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ROOSEVELT JOSEPH SAME ITEM Pe 20e METHOD OF DISPOSITION
1 Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must HARMONY MEMORIAL PARK 12/3 4 Donation 5 Other (Specify) LANDOVER. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY M00091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) PNEUMONIA/RESPIRATORY FAILURE 2 mos. event, DUE TO (OR AS A CONSEQUENCE OF) APLASTIC ANEMIA traumatic 6 mos. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CEREBRAL HEMORRHAGE shows any COMPLETION DF CAUSE 1 TYES 2 NO TY YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖾 UNCERTAIN 🗆 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 | Nursing Homa 5 | Realdence 8 | Other (Specify) 1 YES 2 NO 10 27. MANNER OF DEATH 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? is marked, 1 X Natural 5 Pending м 1 YES 2 ND В 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Bural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide 29s. CENTS IAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 0101049869 MD (VA) NOV. 25, 1994 0 2 3D. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DARRELL COHEN M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 31. DATE FILED (Month, Day, Year)

FC 0 2 1994 1 132. REGISTRAR'S SIDERTURE OR

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

16	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should for within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. INPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
4	il

S NAME (First, Middle, Last)	1	2. DATE OF DEATH		3. TIME OF GEATH
RAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	J =7	30300
			Q I	36965

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	EALTH AND	MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)			1		2. DATE OF DEATH		3. TIME OF OEATH
	SAdie	Elberta		John	SON	MONTH DAY	16 CY	10000
	4. SOCIAL SECURITY NUMBER		in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		HPLACE (State or Foreign
	578-52-6065	1 🗆 M 2 💂 F	92 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Coun	(ry)
	9e. FACILITY NAME (If not institution, give s	street and number)	72	9b. CITY, TOWN O	R LOCATION OF D		9c. COUNTY OF	ange Va.
H	Suburban Hoeni	ital		Dothe			O. O. O. O.	
5	Suburban Hospi			<u>Bethe</u>	saa		Montgo	nery
DIRECTOR	10e. STATE 10b. COUNT	v N/A		Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
		N/ A	wa	shingtor	1			1 ☑ YES 2 ☐ NO
3AL	100. STREET AND NUMBER 2723 Sherman	A		101.	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL		Avenue, N. W	•		20001		US	SA
E	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yee on, Puerto Ricen, etc.)	or No 14, RAC	E — Americen Indian, k, White, etc.
ВУ	2 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES 2	1 🗆 YES				Lack
	15. DECEDENT'S EDU	CATION	10. DECEDENTIO					Lack
1	(Specify only highest grade	completed)	(Give kind of a	WORK done during mos	IN at of working	16b. KIND OF BUS	INESS/INDUSTRY	
7	Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	Mainte			170 01	+ OOA	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Mainte	nance	40 MOTHER'S NA	US GOV		
	Ed Jones						Sumeme)	
띪	19e. INFORMANT'S NAME (Type/Print)		195 MAII INC	ADDRESS (Street o		Bbeth Route Number, City or Town	State 7to Octob	
6	Helen Freeman		1	414. Ups	hur Stre	et, 2001I	r, State, Zip Code)	
	20e. METHOD OF DISPOSITION	206	DI ACE AND DATE	OF DISPOSITION (Ne	n, D. C		CATION — City or To	044
	N Burlel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cem	etery, cremetory or o	ther place)				
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Lyland N	22. NAME AN	D AODRESS OF FA	L 11-25 La	urel Mc	.1 77 7
	NO M	rchall	>			4217 9E	h Stree	al Home Inc
						Washingto	on, DC	20011
	23. PART i. Entar the diseases, or a shock, or haert failure.	complications that caused List only one ceusa on a	l the deeth. Do r ech lina.	not anter the mod	da of dying, auc	h es cardiac or respir	ratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Fine)	. 1						Onset and Deeth
	disease or condition resulting in death)	a. w/m						~1/2 zer
			CONSEQUENCE OF	F):				
8	Sequentielly list conditions,	b. Men	CONSEQUENCE OF					
Ě	If any, leading to immediate cause. Enter UNDERLYING	MA	www.hc	derent				
윤	CAUSE (Diseese or injury	C	CONSEQUENCE OF					
CERTIFICATION	thet initiated events resulting in death) LAST		utto I dem					
E			7					
A P	PART II. Other significent condition	s contributing to death be	ut not resulting i	in the underlying	cause given in	Part I. 24a. WAS AN A	AUTOPSY 24t	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC		Munia	, congetive	" Herry	aulerl	1 D YES 2		COMPLETION OF CAUSE OF DEATH?
ME				/		\mathcal{V}		1 YES 2 NO
ž	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S 🗆 NO 🗆	UNCERTAIL	NI		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT					
SI	1 VES 2 NO	HOSPITAL: 1 Inpatient 2 - ER/Outp	etient 3 DOA	OTHER: 4 Nursing Home	5 Residence	8 Other (Specify)		
E	27. MANNER OF DEATH	28e. OATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJU		28d. DEŞCRIBE HOW IN	JURY OCCURED	
BY	1 Natural 5 Pending 2 Accident Investigation	(ES 2 HO			
ED E	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	- At home, ferm, s	street, fectory, office		28t, LOCATION (Street ar City or Town, State)	nd Number or Rural	Route Number,
ETE	4 Homicide determined					ony or rown, state)		
2	290. CERTIFIER (Check only	CIAN: To the best of my knowl	edge, death occurre	ed at the time, date	end place, end due	to the ceuse(e) end many	ner as stated.	
COMPL		R: On the beele of examination						e) end manner ee stated.
C	296. SIGNATURE AND TITLE OF CERTIFIER	1 1			29c LICENSE NUI	ABED T	204 DATE SIGNE	
00		in /	פח		D 29	Tede MD	> ///	16/94
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED DAUSE OF DE	ATH (ITEM 27) (Type,	Print)		7 /		<i>'</i>
	JOIE A. QUI	NO GITA SOM	3 4) m	ulgener	m sel	hede MD	Wriy	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE	V				
- 0	IN IN VIEW NOW STANK	Ticha Davidson-Ro	anda DO					

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

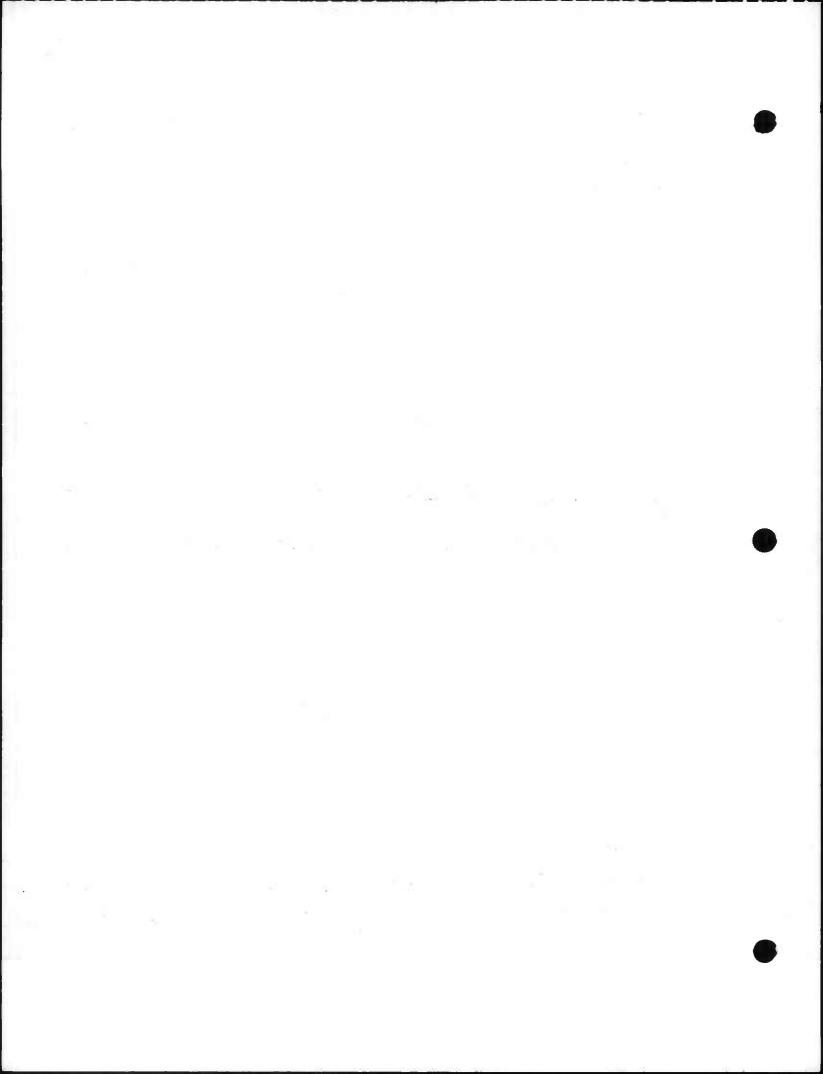
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fire float. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CE	RTIFICA	ATE OI	DEATH	R	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)		nson			DATE OF I	Der 25	MEAR 94	3. TIME OF BEATH
	4. SOCIAL SECURITY NUMBER 240-36-2137 9a. FACILITY NAME (If not institution, give street and number)	6. AGE (In yrs. last	YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De Oct.	18, 192	3 Nort	h Carolina
TOR	PRINCE GEORGES HOSPITAL RESIDENCE OF DECEDENT		9b.		verly	EATH		ince	George's
DIRECTOR	District of Columbia		10c. CITY, TO	ww or Loc lashir	7170				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	3736 Hayes Street, N.			1	of. ZIP CODE 20019				what country? States
B∀	1 Never Merried 2 Married FORCES?	ENT EVER IN U.S. ARM 1 YES 2 X N WAR OR DATES		If yes, i	CENOENT OF HISPA pecify Cuban, Maxic S 2 NO Speci	an, Puerto Ricer	pecify Yes or No- 1, etc.)	Spe	CE — American Indian, ck, White, atc. city: Black
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 1 2	(Gh life.	CEDENT'S USUA We kind of work of DO NOT use reti	done during n red.)	ION nost of working		o of Business	INDUSTRY	
	17. FATHER'S NAME (First, Middle, Last) Will Russell		CIEIR		18. MOTHER'S NA Maria			e)	
TO BE	19a. INFORMANT'S NAME (Type/Print)	19b	. MAILING ADD	RESS (Street	and Number or Rural	Route Number, C	City or Town, State,	Zip Code)	
ř	Barbara Rich	37	58 Hay	es St	reet, N.	E. #5,	Washing	gton,	D.C. 20019
	20a. METHOD OF DISPOSITION TX Burlel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)	cemetery, cren	nd date of dis natory or other p incoln	lace)		0ATE	20c. LOCATION 4 Bren		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	+111			RT FUNER	AL HOME	E		ton, D.C.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	O (OR AS A CONSEQ O (OR AS A CONSEQ O (OR AS A CONSEQ	UENCE OF):	tu o	androl	'ascul	Grahi	luxe	Onset and Death
MEDICAL	PART II. Other significant conditions contributing to					1	. WAS AN AUTOP PERFORMEO?	-	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO C 25. WAS CASE REPERRED TO MEDICAL		F OF DEATH (C)			N 🗆 📗			
Sic	EXAMINER? WE YES 2 NO NO NO NO NO NO NO NO NO NO	☐ ER/Outpatient 3		HER: Nursing Ho	me 5 🗆 Reeldence	8 Other (Sp.	ecify)		
ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	DE INJURY Day, Year)	28b. TIME OF INJURY	28c. If	JURY AT ORK? YES 2 NO		BE HOW INJURY	OCCURED	
	3 Suicide 6 Could not be 4 Homicide determined	OF INJURY — At hong, etc. (Specify)	ne, farm, street	, factory, off	ca		N (Street and Nun wn, State)	nber or Rural	Route Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PRINCIPAL To the best 2 MEDICAL EXAMINER: On the basis of								(s) and manner sa stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER JULIANA AND ADDRESS OF PERSON WHO COMPLETED CA	me M	40 Chan David		20. LICENSE NU	MBER 30	234	ATE SIGNE	(sorth, gay, Year) W 26, 199
	Augusto P. Rochique	ARZ SIGNATURE	1 27) (Type, Print)	19/	ay fu	mch	Cp. Sp.	M	20748
	NOV 3 0 1994 9	rha Davidson	n-Aanda	02	•				,



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTI
1	1. DECEDENT
	4. SOCIAL SEC
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	90. FACILITY N
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	10e. STATE
	MARYI
	10e. STREET A
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Ì	11. MARITAL S
	3 Widowed
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	Elementary
ľ	17. FATHER'S N

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	ERTIFIC	ATE OF	DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
	DONICA JOHNSON				NOV. 22	, 1994	10:25P M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. las		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	S. BIRT Cour	THPLACE (State or Foreign
	215-98-3241 1□M2XF 28	YRS.	UA10	HOURS MIN.			HINGTON, D.C.
_	9e. FACILITY NAME (If not institution, give street end number)		. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF	
ا ق	7012 FARRAGUT STREET (RESIDEN	ICE)	HY	ATTSVIL	LE	PRINCE	GEORGE'S
ည် မြ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c, CITY, T	OWN OR LOCA	TION			10d. INSIDE CITY
DIRECTOR	MARYLAND PRINCE GEORGE'S			ATTSVII	TE		LIMITS?
	100. STREET AND NUMBER			Of, ZIP CODE	ше	10g, CITIZEN OF	WHAT COUNTRY?
	7012 FARRAGUT STREET			20784			S.A.
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR	MED		CENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No.— 14, RA	CE — American Indian.
	t Never Merried 2 Merried FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	10		pecify Cuben, Maxica S 2 📉 NO Specify	n, Puerto Ricen, atc.)		ck, White, etc.
BÁ	3 Widowed 4 Divorced						BLACK
ETED	(Specify only highest grade completed) (Gi	CEDENT'S USI	done during m	ON ost of working	16b. KIND OF BUS	SINESS/INDUSTRY	
	Elementary/Secondary (0-t2) College (1-4 or 5 +) Z YEARS	Do NOT use re	PTION	TCT		PRIVAT	
COMPL	17. FATHER'S NAME (First, Middle, Last)	KECE	TITON		ME (First, Middle, Maiden		<u> </u>
	CLARENCE E. JOHNSON					RTIN	
BE		b. MAILING AD	DRESS (Street		Route Number, City or Town		
۹ ا					HYATTSVILL		ND 20784
ŀ	20s. METHOD OF DISPOSITION 20b. PLACE	AND DATE OF D	-			CATION — City or	
	HARMON Burlel 2 Cremetion 3 Removal from Stata Completely of the HARMON	VY MEM	ORTAL	PARK 1	1/26/94 LA	NDOVER	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME A	ND ADDRESS OF FA	CHITY LICE TO LICE	ME	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE **SUMMUNITY C. BUSCAR TO	mic	7474	LANDOVER	RD, LANDOV	ER MARYT	AND 20785
	23. PART I. Enter the diseases, or complications that caused the de	ath. Do not					Approximate
	shock, or heert fellure. List only one ceuse on each line IMMEDIATE CAUSE (Final						Interval Batwean Onset and Death
	disease or condition resulting in death)	m	neen	defic	iences As	molso	ne 340
	ONE TO JOR AS A CONSEC	QUENCE OF):		0	010		
z	Sequentially list conditions, but To the As A CONSEQ	neg					a money
HIFICATION	If any, leading to immediate cause. Enter UNDERLYING	IUENCE OF):					
음	CAUSE (Disesse or injury that initiated events	DUENCE OF):					
	resulting in death) LAST						1
5	DART II Other classificant on distance and the second state of the						
8	PART II. Other significent conditions contributing to death but not re	eaulting in t	he underlyir	ig ceuse given in	Pert I. 24a. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ااۃ					1 YES 2	NO	COMPLETION DF CAUSE OF DEATH?
Ā	DID TODA CCO HOT CONTENDED TO CALLED OF DE						1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	E OF DEATH			1		
<u>ă</u>	EXAMINER? HOSPITAL:	0.	THED.				
	27. MANNER OF DEATH 28s. DATE OF INJURY	28b. TIME OF		ne 5 Reeldence	6 ☐ Other (Specify) 28d. DESCRIBE HOW II	NUMBY OCCURED	
	1 Natural 5 Pending (Month, Day, Year)	INJURY		DRK?	ave. DEGOTTE HOW I	NOON! OCCURED	
à l	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At hot building, etc. (Specify)	me, farm, stree			281, LOCATION (Street a	and Number or Rural	Route Number,
<u> </u>	4 Homicide determined building, atc. (Specify)				City or Town, State)		- SV 2350W
MPLEIEU	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, der	ath occurred at	t the time, date	end place, and due	to the cause(e) and man	ner se stated	
	Torrock orny						
	one) 2 MEDICAL EXAMINER: On the basic of axamination and/or is	meengetion; it					(e) end manner ee stated.
	one) 2 MEDICAL EXAMINER: On the basis of axamination and/or is 29s. SIGNATURE AND TITLE OF CERTIFIER	Treatigation, II		-RQc. LICENSE NUM			
H H	2 MEDICAL EXAMINEN: On the basic of axamination and/or in	The state of the s					D (Month, Day, Year)
H H	2 MEDICAL EXAMINEN: On the basic of examination and/or in				18ER - 79	29d. DATE SIGNE	
O IO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER (Information and Control of Certifier)					29d. DATE SIGNE	

3. TIME OF DEATH

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Jessie

1 -

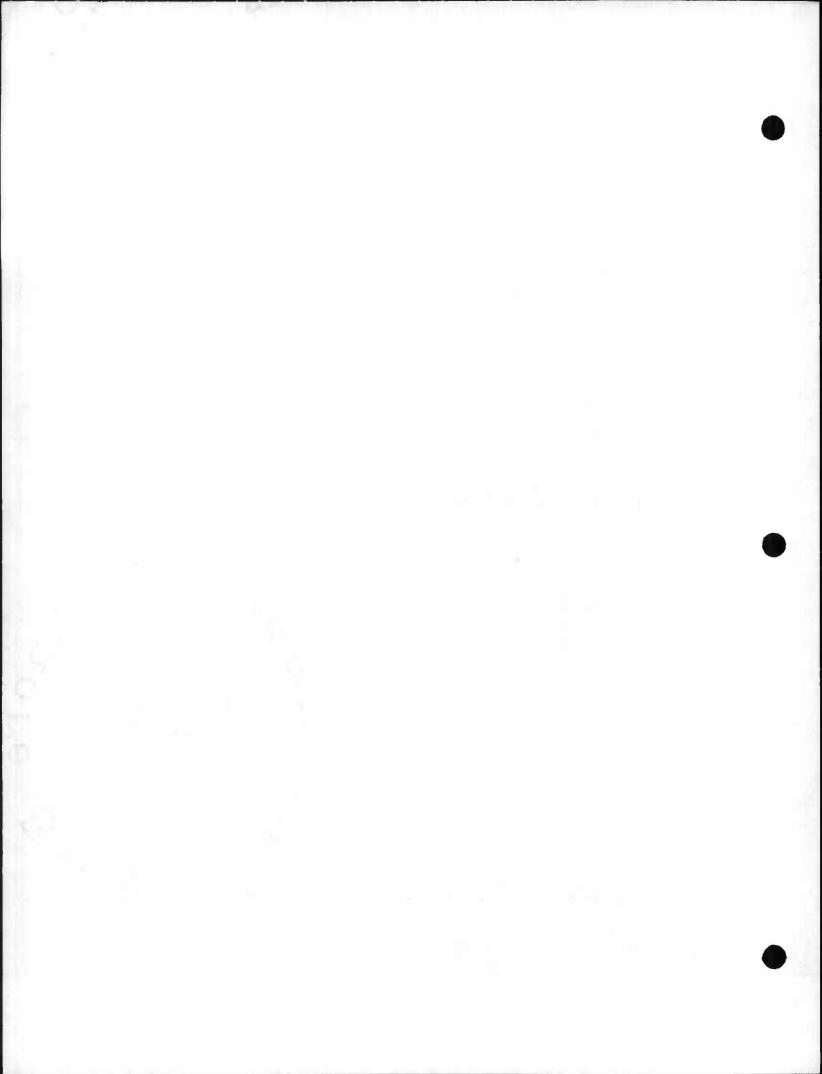
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1994 FAR NOV 19 2:04 A 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
AUG 15 1915 IF UNDER 1 YEAR IF UNDER 24 HRS. RTHPLACE (State or Foreign 231 26 1374 HOURS 1 - M 2X F 79 VDC NC 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 7418 Drum Lea Road Capitol Heights Pr. George's page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 RESIDENCE OF DECEDENT 10e. STATE 10b COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Pr. George's Capitol Heights 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7418 Drum Lea Road 20743 USA hours after death. Page 6 may be retained by the hospital or attending physician, 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 YES 2 X NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES Specify: Black BY COMPLETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highe 12 lery (0-12) College (1-4 or 5+) Domestic Engineer Private Family 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) David Gaynor notified at Mamie Riddick H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joyce Rich same as 10 8 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must the funeral director, Cometery, crematory or other place)
Lincoln Memorial 11/25 Portsmouth, Va examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. ANNE AND ADDRESS OF FACILITY A Home, Inc. 814 Franklin St, Alex, Va medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo **Approximata** shock, or heart fallure. List only one cause on each ilne. Interval Betw **IMMEDIATE CAUSE (Final** Onset and Death traumatic event, the disease or condition resulting in death) executed within DUE TO (OR CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY any 1 YES 2 NO shows 1 YES 2 NO PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The item HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: HOSPITAL OR ATTENDING PHYSICIAN: 1 YES 2 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 4 I Nun 6 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number City or Town, State) COMPLETED 6 Could not be 28 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. IMPORTANT: ME AND TITLE OF CERTIFIER LICENSE NUM BE 五五百 8/99 REE 2 NAME AND ADDRESS OF WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dora Mamodesene MD 7525 Greenway Ctr Dr #207 Greenbelt, Md 20770 31. DATE FILED (Month, D 32. REGISTRAR'S SIGNATURE Day, Year) 1994 wha Davidson-Randall DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

			JACKSON	2. Date of Death Mowth Day Year November 25 1994 8:40 a m
plu		578-12-3716 11XM2□F 75	YRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, War) SEPT. 24, 1919 RICHMOND, VA
2, 3 should	CTOR	9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL RESIDENCE OF DECEDENT	96. CITY, TOWN OR LOCATION OF D	9a. COUNTY OF DEATH PRINCE GEORGE
L. Pages 1,	DIREC	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION WASHINGTON	10d. INSIDE CITY LIMITS? 1X YES 2 \(\text{NO} \) NO
sit permit.	RAL		10f. ZIP CODE 20011	10g. CITIZEN OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	Y FUNER	IF YES, GIVE WAR OR DATES	MED 13. WAS DECENDENT OF HISPA IO If yes, specify Cuban, Maxic 1 YES 2 M NO Specific	y Specify:
	ED BY	15. DECEDENT'S EDUCATION 18a. DE	R 46 CEDENT'S USUAL OCCUPATION ve kind of work done during most of working	16b. KIND OF BUSINESS/INDUSTRY
AND 21 he hospital or detached for u	once. COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 ±)	DO NOT use retired.) CUCK DRIVER	BUREAU OF ENGRAVING
YLA by the	11 m	OTHELLO L. JACKSON	MABEL	ME (First, Middle, Malden Surname) BRIDGEFORTH
E, MAR ay be retained page 5 should	De notified TO BI	BENJAMIN A. JACKSON, 11	o. MAILING ADDRESS (Street and Number or Rural 10 AZALEA COURT LARC	
G of H	must	1 Donation 5 Other (Specify)	ND DATE OF DISPOSITION (Name of CEMET)	DATE 20c. LOCATION — City or Town, State ERY 12/2 ARLINGTON, VA
BALTIM ter death. Page the funeral dire- wal.	examiner	PLOQUE CHINERAL SERVICE LICENSEE	PINCKNEY-SPAI	GLER FUNERAL HOME , N. E. WASH., D. C. 20002
S, P.O. BOX 68760 B. death certificate be executed within 24 hours after a strending physician and completely filled in by the ental Hygiene prior to burial, cremation, or removal	ury, or other traumatic event, the medical CERTIFICATION		Auctastas puence op: puence op: puence op: puence op: puence op:	interval Between Onset and Beath 40 K. With 6M
RECORDS requires that the been signed by the of Health and M	shows any Inju	PART II. Other significant conditions contributing to death but not n	esulting in the underlying cause given in	Pert I. 24s. WAS AN AUTOPSY PERFORMED? 1 VES 2 No COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO
AL RE he law requ thas been e Dept. of	item 23 sh	DID TOBACCO USE CONTRIBUTE TO CAUS 25. WAS CASE REFERRED TO MEDICAL	SE OF DEATH YES NO	
PHYSICIAN: The law this certificate has to with the State Dept	5 ×	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 27. MANNER OF DEATN 28s. DATE OF INJURY	28b. TIME OF 28c. INJURY AT	6 Other (Specify) 28d. DESCRIBE NOW INJURY OCCURED
ate co	mark BY	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — Al ho	INJURY WORK? 1 YES 2 NO me, farm, street, lactory, office	281. LOCATION (Street and Number or Rural Route Number,
DIVISION OR ATTENDING DIRECTOR: After	item 28 i	4 Homicide determined building, etc. (Specify)		City or Town, State)
The Hospital (The Funeral D filed within 72 ha	= 3	(Check only CERTIFTING PHYSICIAN: 16 the best of my knowledge, da		time, data and place, and due to the cause(s) and manner as stated.
THE H	POH BE	29h/SIGNATURE AND ATLA-OF CERTIFIER AND	Alway 200. LACENSE NU	29d. DATE SIGNED (Music). Day 1944
10		Bername and address of person who completed cause of Death (ITES	- D	Acioi Clinton MI) 2013
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julian Davidson-1	ange	

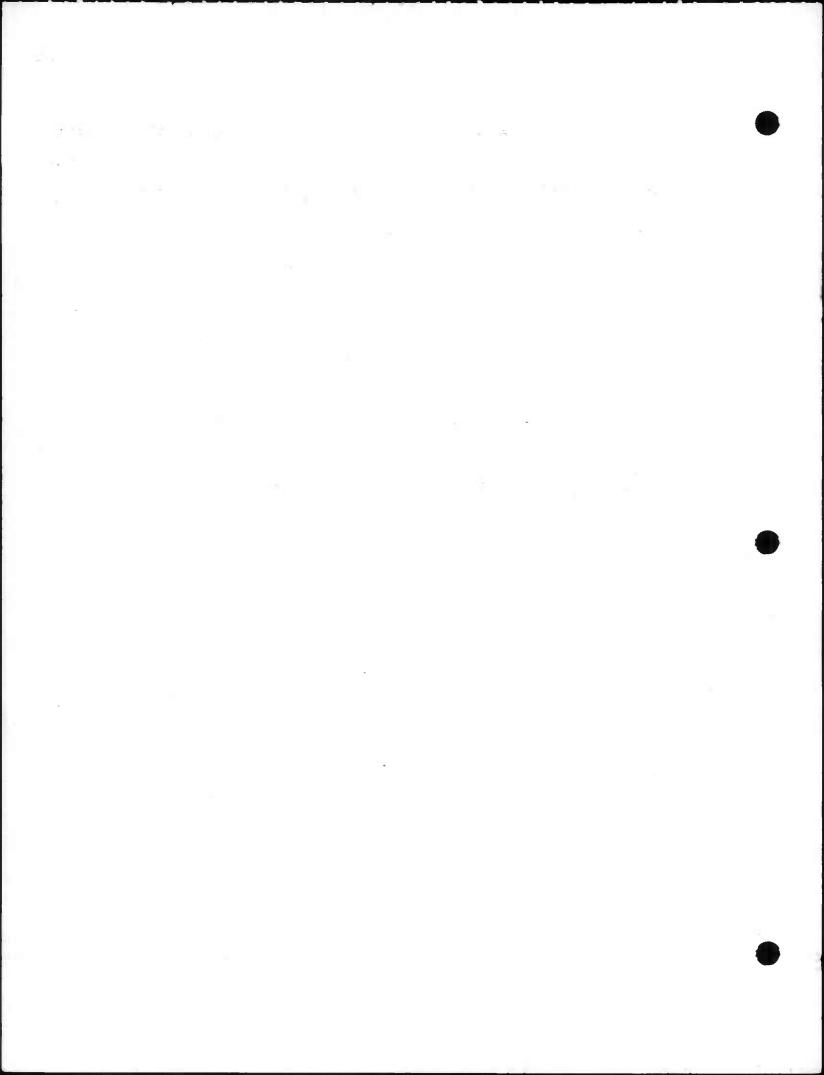
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IVISION OF VITAL RECORDS,	
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF OEATH		3. TIME OF DEATH
	CASBY EDISON	JOHNSON				Navember	27 9ª	
			n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. B	RTHPLACE (State or Foreign
	577-52-2425	M 2 □ F	89 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) MAY 18, 19		IANGLE, VA
	9a. FACILITY NAME (If not institution, give stree			9b. CITY, TOWN	OR LOCATION OF DEA		9c. COUNTY C	
OR	Doctors Community	y Hospital		Lanho	rm. MD		Phino	e Georges
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY						1 marici	
DIRECTOR		17/2		Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?
	N/A	N/A	WA	SHINGTO	N, DC			1 X YES 2 NO
FUNERAL	Series Series			100	A THE PARTY OF THE		10g. CITIZEN (OF WHAT COUNTRY?
INE	317 ANACOSTIA	AVENUE NE 2. WAS DECEDENT EVER IN	IIC ARMED	1 12 111 0 000	20019	C ORIGIN? (Specify Yes	USA	
	1 Never Married 2 Married	FORCES? 1 YES	2 XNO	If yes, sp	ecify Cuban, Maxican	, Puerto Rican, atc.)		IACE American Indian, Black, White, alc.
В	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DA	IES	1 U YES	2 XNO Specify:		s	BLACK
COMPLETED	15. OECEDENT'S EDUCAT (Specify only highest grade cor	ION molested)	18a. DECEDENT'S			16b. KIND OF BUS	SINESS/INDUSTR	Y
TH.		College (1-4 or 5+)	life. Do NOT us	vork done during mo e retired.)	ist or working			
MP	8th		MACH	INIST			GOVT.	
00	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	IE (First, Middle, Maiden	Surname)	
BE	PETER JOHNSON	Y HOWARD						
2	194. INFORMANT'S NAME (Type/Print) JACQUELINE ROBINS					LANE FT. V		
il	20a. METHOD OF DISPOSITION							
	1X Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I Irom State ceme	PLACE AND DATE Of stery, crematory or of	her place)	ame of		CATION — City o	
	21. SIGNATURE OF FUNERAL SERVICE LICEN		NCOLN CE		ND ADDRESS OF FAC	<u> 12-1 SUI</u>	TLAND	, MARYLAND
	* (110,00,10	& ROD	Whon	J.E	. JENKI	NS FUNER		
-	Viamana	()- Du	NOOY	7474	LANDOVE	R ROAD L	ANDOV	ER, MARYLAND
	23. PART I. Enter the diseases, or com ahock, or heart failure. Lis	t only one cause on as	the death. Do n ch lina.	ot antar tha mo	da of dylng, such	as cardiac or respi	ratory arrest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final disease or condition	DECOI	OTAG	DU -	TAICHE		4-10	Onset and Death
	resulting in death) a	DUE TO (OR AS A	CONSECUENCE OF	1 -	-NO OF	FICI	CVC	7
_		ACDIR	ATTO A) 00	1EUM	DALLA	Paren	
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	n:		0,011)	No Car	
S	cause. Entar UNDERLYING CAUSE (Disease or injury	SEPTIC	-01	=CU1	RE UL	CER.		
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF			^	1 0	20
CERTIFICATION	resulting in death) LAST	SIP-C	V/+;	7/b-	-CARCI	NOMA PA	COSTAI	(
	PART II. Other significant conditions of	ontributing to death bu	it not resulting i	n the Underlyin	g causa givan in P	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICAL	ANEMIA:	HYPOT	HYRY	21016	M.	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
<u></u>	HE (JAC	MAIN			1 YES 2	2000	OF DEATH?
Σ.	DID TOBACCO USE CONTRIB	SLITE TO CALISE OF	DEATH VE	SINOL	UNCERTAIN		' I	1 U YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEAT		1 OIACEKIAIIA			/ ///
SIC	EXAMINER?	OSPITAL:	itient 3 DOA	OTHER:	e 5 🗆 Realdence S	Other (Specify)		
ξ	27. MANNER OF PEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. T/M	OF 28c. INJ		28d DESCRIBE HOW IN	NJURY OCCURED)
ВУБ	1 Natural 5 Pending Investigation	(WORD, Day, 19al)	1111	M 1 🗆		/	_	
	3 Suicide 8 Could not be	28a. PLACE OF INJURY - building, ac. (Specif	— At home, Jarm, a	treet, lectory, offic	•	281. LOCATION (Street a City Town, State)	ind Number or Ru	ral Route Number,
	4 Homicide detarmined							
PL	29a. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the beat of my knowle	dga, death occurre	d at the time, data	and place, and due to	o lhe cause(a) and man	ner as stated.	
S 1	one) 1 MEDICAL EXAMINER: 0	On the basis of examination	and/or investigation	n, in my opinion, c	leath occured at the ti	lme, deta and placa, and	d due lo the cau	se(a) and manner as stated.
ō								
E COMPLETED	29b. SIGNATURE AND TITLE OF CERTIFIE	/ Kows	~ 0		29c. LICENSE NUME	BER	290. DATE SIGN	ED (Month, Day, Year)
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1000	20		D-34	525	▶ /	27/94.
	29b. SIGNATURE AND TITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,		D-34	525	▶ 1(/	27/94.
BE	86	OMPLETED CAUSE OF DEA AOOO — 32. REGISTRAR & SIGNA AMOR DE SIGN	MITCH	FLVILL	D-34	525	▶ 1(/	27/94. 15/MD-20716



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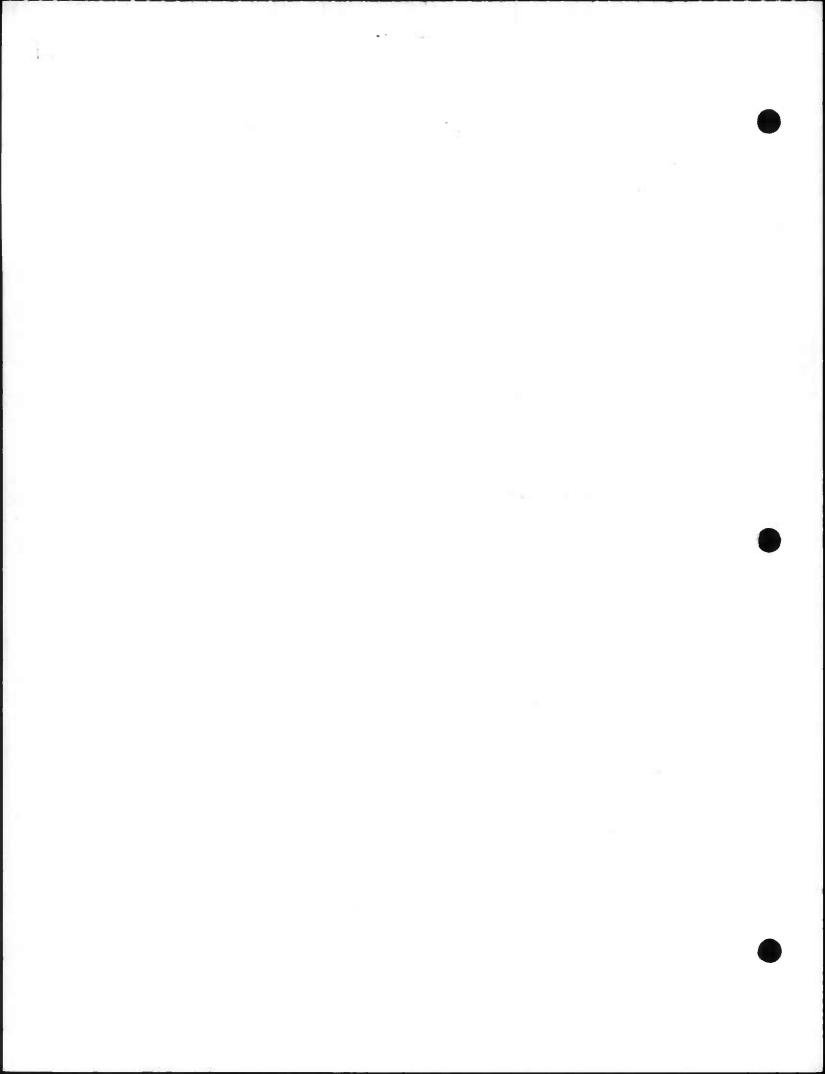
STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MAYBELLE IMOGENE OVEMBER 29.1994 **JENKINS** 2:11 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign July 21, 191 1 M 2 X F Washington D. 578-22-6318 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PHYSICIANS MEMORIAL HOSPITAL RESIDENCE OF DECEDENT LA PLATA CHARLES 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Bryans Road Charles Maryland 1 TES 2 TO NO permit. 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. Lot 28, Bryans Road Trailer Park 20616 funeral director, page 5 should be detached for use as the burial-transit attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: Specify: BY 3 🔀 Widowed 4 🗌 Divorced White ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET retained by the hospital or Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Sales Clerk Retail once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) (Unknown) notified at Blanche John Joseph Kendrick BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12617 Red Fox Lane, Lusby, Md. 20657 Debra Gavazz Раде 6 тау be must be 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Cedar Hill Cemetery Suitland, Maryland 4 Donation 5 Other (Specify) 12-2-94 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Williams Funeral Home, P.A. death. M00668 Rt. 225 & Glymont Rd., Indian Head, Md. 2064) completely filled in by the rial, cremation, or removal. within 24 hours after 23. PART I. Enter the disease, or complications that caused the disease, ahock, or heart failure. List only one cause on each line eases, or complications that caused the death. Do not enter the mode of dying, auch as cardisc or respiratory errest, Interval Between 9 IMMEDIATE CAUSE (Finsi Onset and Dsath PULMONARY EDEMA the disesse or condition few hours resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) executed and com CHRONIC OBSTRUCTIVE LUNG DISTASE DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially ilst conditions, prior to if any, leading to immediate CLGARETTES ABUSE cause. Enter UNDERLYING CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 the after Mental Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS by AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? FRACTURED GREATER TROCHANTER shows any OF RIGHT FEMUR. HISTORY OF MYDEARDVAL INPARCED 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one Item EXAMINER? HOSPITAL: ATTENDING PHYSICIAN: Inpatient 2 ER/Oulpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, With this 1 Natural 5 Pending 1 YES 2 NO BY After death Investigation 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 8 Could not be hours after Item 28 Is DIRECTOR: 4 Homicide 29a. CERTIFIER

(Chark and)

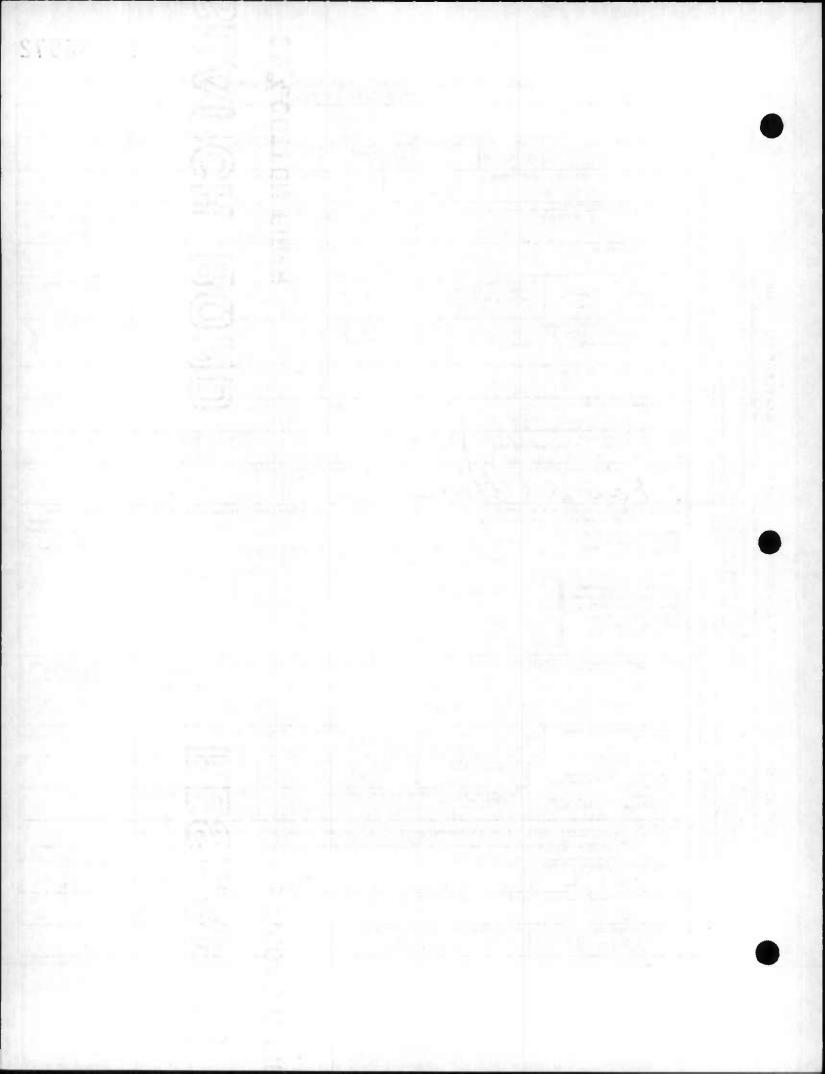
1 CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. OR TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: It its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) amelio C. de le faz 129/94 D-16160 M-D 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AURELIO C. DE PAZ M.D. P.O. BOX 1230 LA PLATA MD. 20646 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julia Davidson Randall DEC 0 5 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	CERTIFICA				GIENE 3. NO.		
	1. DECEDENT'S NAME (First, Middle, Last			- 94	5.5	2. DATE OF DE	ATH DAY	YEAR	3. TIME OF DEATH
	Thomas 4. SOCIAL SECURITY NUMBER	Lindbergh	Jarvis yrs. last birthday) IF t	JNDER 1 YEAR	IF UNDER 24 HRS.	Novemb		-	9:35 A
	_218-20-3996	1X M 2 🗆 F	67 YRS. MON	7	HOURS MIN.	June 13	Year)	Country)
	9e. FACILITY NAME (If not institution, give	street end number)		CITY, TOWN	OR LOCATION OF D			NTY OF DE	/land
DIRECTOR	910 Sunday Driv	re		Dei	nton			Ca	roline
₹ C	10s. STATE 10b. COUN	ТҮ	10c. CITY, TO	WN OR LOCA	TION			T	10d. INSIDE CITY
	Maryland	Caroline			Den	ton			LIMITS?
FUNERAL	100. STREET AND NUMBER 910 Sunday Drive			101	f. ZIP CODE	20			HAT COUNTRY?
UNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN I	U.S. ARMED	13. WAS DEC	216			J.S.A	- American Indian.
BY FI	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO ES	If yes, sp	ecify Cuben, Mexico	en, Puerto Rican, e		Black, Specify	White, atc.
ED B	16. DECEDENT'S EC	3/51-10/51	16e. DECEDENT'S USU	AL OCCUPATION	ON	Last Kinin	OF BUSINESS/INC		casian
ETE	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4 or 8 +)	(Give kind of work of life. Do NOT use reti	done during mo	ost of working	100. KIND	OF BUSINESS/INC	JUSTRY	
MPL	11 HS grad.	None	Owne	er		Au	tomobile	e Dea	lership
COMP	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle,			
BE	John Ri 19s. INFORMANT'S NAME (Type/Print)	nggold Jarvis		DECR /Compt	Eliz	zabeth	The second second	0-4-1	
2	Marjorie Chamber	s Jarvis	- Comment of the last		rive, De			216	29
	20e. METHOD OF DISPOSITION 1 Burlel 20 Cremation 3 Re	20b. F	LACE AND DATE OF DIS	SPOSITION (No	ame of	DATE 2	DC. LOCATION -		
	4 Donation 6 Other (Specify)	Eas	stern Shor				Georgeto	own,	Delaware
	21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE // h	200		nd address of Fa ce Funera		P.A.		
	1 Paudisp	16:11601	~	Draw	ver B, De	enton, M	[aryland		529
		complications that caused to List only one cause on esc	the death. Do not e ch line.	nter the mo	de of dying, suc	ch ss cardlec o	respiratory an	rest,	Approximats interval Batwee
	IMMEDIATE CAUSE (Finsi disease or condition	PROST	BTE.	C	MAIC E				2 YAS
	resulting in death)		CONSEQUENCE OF):		,4,4 €				
N	Sequentially list conditions,	b							
ATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):						
RTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF):						
FR	resulting in death) LAST	d							
AL CE	PART II. Other significant condition	one contributing to death but	t not resulting in th	e underlyln	g Csuse given in	Part I. 24a. V	WAS AN AUTOPSY	24b.	WERE AUTOPSY FINDING
							YES 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC							120 1 200		OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТ	HER:	LACE OF DEATH (C)				
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpat 28a. DATE OF INJURY	26b. TIME OF	28c, IN,	10 5 Residence		HOW INJURY OC	CURED	
ВУ Р	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	INJURY	WC	YES 2 NO				
0	3 Suicide 6 Could not b	26e. PLACE OF INJURY -	- At home, ferm, street	, factory, offic	:0	28f. LOCATION City or Town	(Street end Number	or Rural Ad	oute Number,
ETE	4 Homicide determined						4		
COMPLET	onel	SICIAN: To the best of my knowle							
00		IER: On the besis of examination	end/or investigation, in	my opinion, o			ace, and due to the	ne ceuse(e)	end manner es stated.
BE	29b. SIGNATURE AND TITLE OF CHITIF	B O	8	~	D A	MBER 7 3 4	29d, DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON Y	HO COMPLETED CAUSE OF DEAT	TH (ITEM_27) (Type, Print	3.0	W 01	020	1 /	1-1.	3-95
	Stephen P. Carr				e, Easto	n, Mary	Land 21	.601	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE				~		
	NOV 16 '94	Julia Davidso	n-Handele						



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

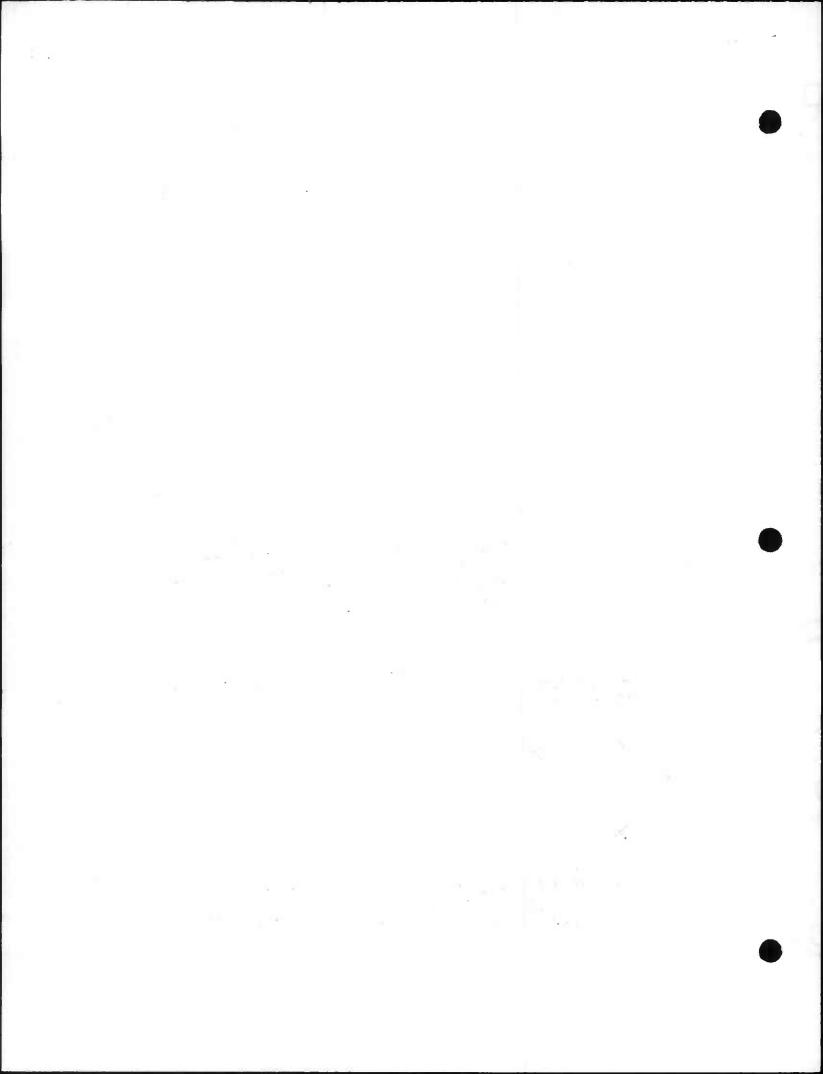
FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH			
20220	rances		Korn			Ĩ, 1992		
550 00 1101	5. SEX 6. AGE	(In yrs. last birthday) 7 4 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 8,		BIRTHPLACE (State or Foreign Country)	
						9c. COUNTY	Virginia	
Physicians Memori		1	La Pla	ta		Char		
10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	TION			10d. INSIDE CITY	
Maryland Charle	èS		White	Plains			1 TES 2 NO	
100. STREET AND NUMBER 4710 Duffield Roa	ad		101	20695		10g. CITIZEN	OF WHAT COUNTRY?	
	2. WAS DECEDENT EVER II FORCES? 1 YES				NIC ORIGIN? (Specify Ya	or No- 14.	RACE — American Indian,	
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			2 XNO Specif	en, Puarto Ricen, etc.) ý:		Black, White, etc. Specify: White	
15. DECEOENT'S EDUCAT (Specify only highest grade co		18a. DECEDENT'S (Give kind of w	ork done during mo		16b. KIND OF BU	SINESS/INDUST	RY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Hom	emaker		own Hom	2		
17. FATNER'S NAME (First, Middle, Last)		11011	CHARCE	18. MOTNER'S NA	ME (First, Middle, Maiden			
Charles HersheyHi	nkle				cie Christ			
Daniel K. Korn					Houte Number, City or Tow hite Plain			
20a. METNOD OF DISPOSITION		D. PLACE AND DATE O	F DISPOSITION (No	me of		CATION — City		
1 Surial 2 Cremation 3 Ramovi		edar Hil			12-5 Sui	tland,	MD	
Shirley Capon	rlille	400844	Huntt		Home, Inc , Waldorf,		504-0156	
23. PART I. Enter the diseases, or con shock, or heart failure. Lis	mpilcationa that cause	d tha death. Do n	ot antar tha mo	da of dying, suc	th as cardiac or reap	ratory arrest,	Approximsta	
iMMEDIATE CAUSE (Final disease or condition resulting in death)	Respir	ialong.	fally	u			interval Between Onset and Death	
	1 P. MAN	MT ONL	iral es	Susia	V			
Sequantially list conditions, If any, leading to immediate	DUE TO (OR AS A	A CONSEQUENCE OF	- /	10	1 -	1721		
cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO JOR AS	A CONSEQUENCE OF	um pe	Monar	y allsla	~		
resulting in death) LAST					U		1	
PART II. Other significant conditions of	contributing to death t	out not resulting in	the underiving	cause given in	Part I. 24a, WAS AN	AUTORSY	24b. WERE AUTOPSY FINDINGS	
		- trot roughting n	Title discorrying	g cause given in	PERFOR	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE	
					1 YES 2	(V)-4(O	OF DEATH?	
DID TOBACCO USE CONTRIB	BUTE TO CAUSE C	OF DEATH YE	S NO	UNCERTAI	N 🗆			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:			•		
1 VES 2 NO 1	25e. DATE OF INJURY	petiant 3 DOA	4 - Nursing Nom		6 Other (Specify)			
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	26b. TIME INJU	JRY WO	URY AT RK? YES 2 NO	26d. DEŞCRIBE NOW I	NJURY OCCURE	ED	
3 Suicide S Could not be detarmined	28a. PLACE OF INJURY building, atc. (Spec	f — At home, farm, st cify)	reet, factory, office		281. LOCATION (Street City or Town, State)		tural Route Number,	
29a. CERTIFIER CERTIFYING PHYSICIA	IN: To the beat of my know	riedge, death occurre	d at the time, date	and place, and due	to the cause(s) and mai	ner as stated.		
one) 2 MEOICAL EXAMINER:	On the trais of exceptnation	n Ind/or Investigation	ı, in my opinion, d	eath occured at the	time, data and place, an	d due to the ce	use(a) and menner as stated.	
295. SIGNATURE AND TITLE OF CERTIFIER	VAH	are		29c LICENSE NUI D-22574	MBER	29d. DATE SIG	GNED (Month, Day, Year)	
R. Timothy Pace, MD	COMPLETED CHIP OF DE Waldorf Me			Box 24	9. Waldorf	.MD 20	0604	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	MTURE P	, = 10		-,IdoII	, 20	7004	
DEC 0 6 1994	Julia di dua	Wast individually						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ID / DEPART			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) Har	ry Harvey K	line			2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF	i 94	3. TIME OF DEATH . 7:20 P. M
		SEX 6. AGE (In		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June19,19	8. BIRTI Count Md	HPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give atreet Washington County H				R LOCATION OF DE		9c. COUNTY OF E	DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
		ington		Smithsb	ırg			LIMITS? 1 YES 2 XNO
FUNERAL	3116 Black Rock Rd			101	ZIP CODE 2178	3	U.S.A.	WHAT COUNTRY?
Β¥	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes, spi	ENDENT OF HISPAN celfy Cuban, Maxica 2 NO Specify	IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	Spec	E — American Indian, k, Whita, atc. idy: 110
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)	ION npleted) College (1-4 or 5+)	life. Do NOT use	rk done during mo: retired.)			SINESS/INDUSTRY	
N N	17. FATHER'S NAME (First, Middle, Last)		mach	Inist	10 MOTUSD'S NA	ME (First, Middle, Meiden	and die	co.
BE C	Harvey	Russell Klir			Pear.	l Mazie Wo	lfe	
2	Betty J. Frazier					Smithsbur		21783
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Ramoval 4 Donatton 5 Other (Specify)	from State 20b. PI	ACEAND DATE OF	disposition (Na or place) Cemete	ne of Pry	1	cation — city or to find the first control of the f	
	21. SIGNATURE OF FUNERAL SERVICE FRENC			Donald	B. Thor	npson Fune	ral Home	
CERTIFICATION	23. PART Later the diseases, or composed to the process of the pro	DUE TO (OR AS A CO	DULMO	NARGARA	L ARR	\cap		Approximete Interval Batween Onset and Death
PHYSICIAN: MEDICAL CI	PART II. Other significant conditions of the NAL ALL DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL	ONIC. OBST URE UTE TO CAUSE OF	Roctiv	E LUA)6 D13+	PERFOR		MERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICI		OSPITAL:		THER:	5 Residence	6 Other (Specify)		
	27. MANNER OF DEATH Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU	IRY AT	28d. DESCRIBE HOW II	NJURY OCCURED	
TED BY	2 Accident investigation 3 Suicida 6 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stre	eet, factory, office		281. LOCATION (Street a City or Town, State)	and Number or Rural i	Route Number,
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O	N: To the best of my knowled						s) and manner as stated.
TO BE	296. SIGNATURE IND THE OF DERTIFIER	rMA.			29c. LICENSE NUM	IBER 1555	≥ 12.	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO CO	32. BEGISTRAR'S SIGNATU	MILED	SVILL	E, MI	2177	3	



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		- 0	ENTIF	ICATE	IF DE	4111	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) Emma	Haller	Kc	h1h	oss			2. DATE OF DEATH MONTH Dec 1	DAY 1 9	9 4	3. TIME OF DEATN 1:55 a m
	4. SOCIAL SECURITY NUMBER	AGE (In vrs. les	yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7.						PLACE (State or Foreign		
	577-42-9010	37	MONTHS DAVE HOUSE AND (N				(Month, Day, Year)	1007	Countr	γ)	
	9e. FACILITY NAME (If not Institution, give s) /	96. CITY, TOWN OR LOCATION OF DEATH						INTY OF D	laryland
<u>د</u> ا			I mai -								
[은	Springbrook Adv	entist r	vui Siii	ıg	211	ver	Sprin	ıg	MO	ntgo	mery
<u> </u>	10e. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN OR L	CATION					10d. INSIDE CITY
DIRECTOR	Md. Mon	tgomery		S	ilver	Spr	ng				LIMITS? TX XYES 2 NO
	10e. STREET AND NUMBER					10f. ZIP CO	DE		tog. CIT	IZEN OF W	WHAT COUNTRY?
EN	13208 Betty La	ne				209	04		I	J.S.	A
FUNERAL	11. MARITAL STATUS	12 WAS DECEDENT S	VER IN U.S. AR	MED	13. WAS			IC ORIGIN? (Specify Y			Ω . E — American Indian,
	1 Never Merried 2 Merried	FORCES? 1	YES 21 OR DATESX	NO	If yo	, specify Cu	ben, Mexicer O Specify	, Puerto Rican, etc.)		Black Speci	r, White, etc.
8	3 Widowed 4 Divorced				'-	X	o opecity			Speci	white
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	USUAL OCCU	PATION	kina	16b. KIND OF B	JSINESS/IN	DUSTRY				
	Elementary/Secondary (0-12)	College (1-4 or 5+)	lite	Do NOT us	vork done durin se retired.)	, most or wo	ning				P.
M	12		reta	ailer			He	cht	Co.		
8	t7. FATNER'S NAME (First, Middle, Last)				18. M	THER'S NAM	AE (First, Middle, Maide	n Sumeme)			
BE	Joseph Haller				Gertr	ude Tit	us				
0	19e. INFORMANT'S NAME (Type/Print)						oute Number, City or To				
-	Nancy Young	3208	B Bet	ty La	ı. Si	lver Sp	ring	.Md.	20904		
	28a. METNOD OF DISPOSITION 1	oval trom State	20b. PLACE		OF DISPOSITIO	N (Name of		DATE 20c. L	OCATION -	City or To	wn, State
	4 Donation 5 Other (Specify)			onoc	acv			12/5 B	211	svi1	lo Md
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1/_				ESS OF FAC	жыту ral Home			-0, 114.
	1 Willia	C Kil	-					. Md. 20			
	23. PART I. Enter the diseases, or o	complications that c	eused the de	eth. Dp r	not enter the	mode of	lying, such	es cerdiec pr res	olratory er	reet,	Approximete
	ehock, pr heart fellure. IMMEDIATE CAUSE (Finel	List only one ceuse	on each line	3.							Intervel Between Onset and Desth
	disease or condition	1.00	11.111	lo	Das	-111	1-				Onest and bestin
	resulting in deeth)	DUE TO (O	R AS A CONSE	OUENCE OF	F):	MUN (119				
z											1
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate	DUE TO (O	R AS A CONSE	OUENCE OF	F):						
8	ceuse. Enter UNDERLYING CAUSE (Disesse or Injury	c									
E	thet initieted events	DUE TO (O	R AS A CONSE	QUENCE OF	F):						
EH	resulting in deeth) LAST	d									
0	PART II. Other significent condition	s contributing to de	eth but not i	resulting	In the under	vina caus	alven in i	Part I. 24a, WAS A	M ALITOREY	245	. WERE AUTOPSY FINDINGS
EDICAL			, , , , , , , , , , , , , , , , , , , ,	osoiting i	in the onder	ying caus	giveniii	PERFO	RMED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
						_		1 X YES	2 🗌 NO	1	OF DEATH?
Σ	DID TOBACCO USE O	ONTRIBILITE	TO CALL	SE OF	DEATH	YEC I	ON F	70			1 TYES NO
A	25. WAS CASE REFERRED TO MEDICAL			01							
PHYSICIAN:	EXAMINER?	HOSPITAL:			QTHER:		DEATH (Che				
₹	27. MANNER OF DEATN	1 Inpetient 2 E		28b. TIM		Home 5 INJURY AT	Reeldence	8 Other (Specify)			
	1 Natural 5 Pending	(Month, Day,		INJ	URY	WORK?		28d. DEŞCRIBE NOW	INJUHY OC	CURED	
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF I	NJURY At he	me term s			_ NO	201 LOCATION (Com-	and Munh	a as Burni G	Service Albumb
	4 Nomicide S Could not be	building, etc	. (Specify)	Ano, term, 1	niteer, rectory,	Dillica		28t. LOCATION (Street City or Town, State	end Numbe	er or Hurai H	10Ute Number,
<u> </u>	29e. CERTIFIER				<u></u>						
M P	(Check only	CIAN: To the best of my									
COMPLET	2 MEDICAL EXAMINE		nination end/or	investigatio	n, in my opini	n, death oc	curad et the	time, date end place, o	nd due to t	he ceuse(s	end menner es steted.
BE	296. SIGNATURE AND TITLE OR CERTIFIES	10 1	di .			29c. L	CENSE NUM	BER	29d. DA	TE SIGNED	(Month, Day, Year)
2	4 gay	SCAUTION	2			V.	379	125	1	2/2	-124
	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITE	М 27) (Туре,		_		1 -1	_	111	
		drisahi			9801	ben	- Ste-	the Silve	- FS/	ortho	47 20902
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'	SIGNATURE AUGULEEN-1	8 1 1	,		0			-	, , ,
- 1	DEC 0.7 1994	1 /	A. Masumer	woodly	1						

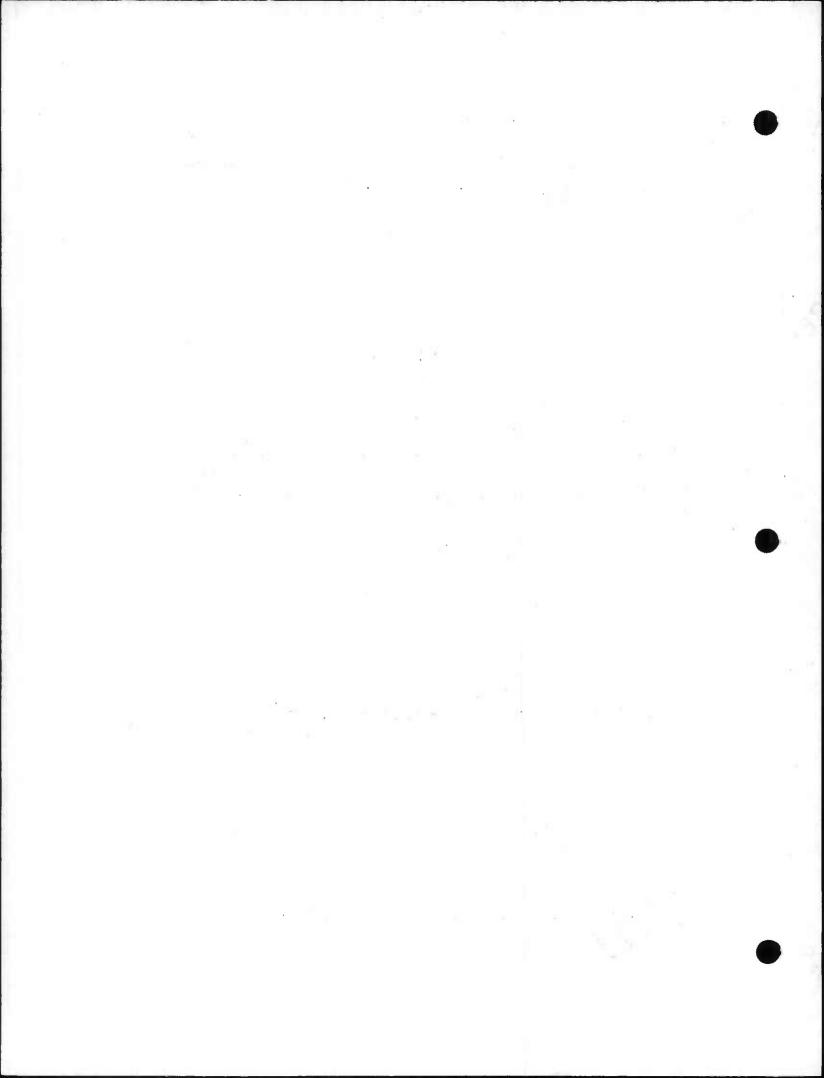
heresa BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)	*							2. DATE OF	DEATH			3. TIME OF DEATH
		THERE	ESA KLINE				December 2 94				5/3 M			
- }	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In y	rs. last birthd	//	NOER 1 YEAR	-	R 24 HRS.	7. DATE OF (Month, D	BIRTH			PLACE (State or Foreign
	220-34-539	5	6 YR	S. MONT	HE DAYS	HOURS	MIN.	Sept.	26,	1938	Ger			
	9e. FACILITY NAME (If not in		,				CITY, TOWN		ION OF DE	ATH		9c. COU	NTY OF DE	EATH
PO	Union Hosp		f cecil	County	7	1	Elkto	n				Cec	il	
딥	RESIDENCE OF DEC	10b. COUNTY			10c.	CITY, TOY	VN OR LOC	ATION						10d. INSIDE CITY
DIRECTOR	Maryland Cecil Elkton													LIMITS?
	10e. STREET AND NUMBER						11	of. ZIP COO	DE		-	10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	20 Deer Ru	n Park	way					219	21			U.	S.A.	
S	11. MARITAL STATUS		12. WAS DECEDEN							IIC ORIGIN? (or No-		— American Indien,
BY F	1 Never Merried 2 3 Widowed 4 X Divo		FORCES? 1 IF YES, GIVE V					S 2 X NO		n, Puarto Rici	in, etc.)		Specif	, White, etc.
														White
	15. DECI (Specify only	-	 Give kind life. Do NO 	of work di	one durina n	TION nost of work	ing		nd of Bus apery			mont		
1 2	Elementary/Secondary (0	-)	Seam		-				nstru			meric		
COMPLETED	17. FATHER'S NAME (First, MI	iddle, Last)			000000			18. MO	THER'S NA	ME (First, Mide				
	Fra								Sch1	,	mann			
TO BE	19e. INFORMANT'S NAME (7)						Route Number,							
F	Mary E. Cl	503	Ho1	lings	wort	n Ave	nue -	Elkt	on,	MD	21921			
	20a. METHOD OF DISPOSITI	ION on 3 🗆 Rema	val from State	20b.PL	ACE AND DA	TEOF DIS	POSITION (Vame of		1216	20c. LO	CATION —	City or To	wn, State
1X) Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Immaculate Conception Cem. 1994 Cherry H 21. SIGNATURE OF FUNERAL SERVICE LICENSEE										ry Hill, Maryland				
Hicks Home for Funeral									s, P	.A.				
	Donald & Hickon 103 West Stockton Street Elkton, MD 21921-5521													
	23. PART I. Enter the di shock, or he	iseeses, or co aart fallure. L	omplicatione the list only one ceu	t ceused th	e deeth. D	o not e	nter the m	ode of d	ying, suci	h ss cerdle	c or reepi	ratory sr	rest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Fin		0											Onset and Death
	disease or condition resulting in death)	→	. dep	tie 8	work									
_			008 10	THUN	MSEQUENC	E OF):								
CERTIFICATION	Sequentially list conditi			(OR AS A CO		E OF):								
CAT	If any, leading to immed cause, Enter UNDERLY! CAUSE (Disease or inju	NG												!
E	that initiated events		DUE TO	(OR AS A CO	NSEQUENC	E OF):								
Ä	resulting in desth) LAS		J											
	PART II. Other significs	nt conditions	contributing to	death but	not resulti	ng In the	underlyl	ng ceuse	given in	Pert i. 24	In. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL	Houle	Myor	ardial	Justo	recli	20					PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	Cir	rhosi	s Live	2										OF DEATH? 1 YES 2 NO
	DID TOBACC	O USE	CONTRIBUT	E TO C	AUSE	OF D	EATH	YES [N					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HO9PITAL:					PLACE OF	DEATH (Ch	ock only one)				
YSI	1 TYES 2 NO		1 I Inpatient 2	ER/Outpatie	int 3 🗆 DO		HER: Nursing Ho	me 5 🗆 R	lesidence	6 Other (S	ipecity)			
H	27. MANNER OF DEATH	Pending	28e. DATE OF (Month, D		28b.	TIME OF INJURY	V	JURY AT		28d. DESCR	IBE HOW I	JURY OC	CURED	
В	2 Accident	Investigation						YES 2	□ NO					
E		Could not be	28e. PLACE O	atc. (Specify)	At nome, tar	m, street,	factory, off	Ice		City or	ON (Street e Town, State)	nd Number	r or Rural A	loute Number,
	4 Homicide	datarmined	bulloning,	attat (opcomy)										
	no- operation	datarmined				= = T.A.		72.55	- 110					
MPLE	29a. CERTIFIER (Check only	TEYING PHYSIC	CIAN: To the best of	my knowledg										
	29a. CERTIFIER (Check only one) 1 CERT	TIFYING PHYSIC	CIAN: To the best of	my knowledg				death occu	ared at the	time, date en		d due to th	ne ceuse(s)	end menner ee stated.
BE COMPLETED	29a. CERTIFIER (Check only	TIFYING PHYSIC	CIAN: To the best of	my knowledg				death occu		time, date en		d due to th	ne ceuse(s)	end menner ee stated. (Month, Day, Yeer)
	29a. CERTIFIER (Check only one) 1 CERT	DEFINITION OF CHATTER	CIAN: To the best of a: On the basis of e	my knowledg	nd/or Investig	ation, in i		death occu	ared at the	time, date en		d due to th	ne ceuse(s)	
H	29a. CERTIFIER (Check only one) 1 № CERT 2	OF CENTIFIER PERSON WHO	CIAN: To the best of at: On the basis of a	my knowledg	(ITEM 27)	stion, in i	my opinion,	29c LIC	ENSE NUM	time, date en		d due to th	ne ceuse(s)	
H	29s. CERTIFIER (Check only one) 1 CERT 2 MEDI 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	OF CHITIFIER PERSON WHO EV 9 M • Weer)	CIAN: To the best of at: On the basis of a	my knowleds camination er SE OF DEATH Norti	(ITEM 27) (I	intion, in i	my opinion,	29c LIC	ENSE NUM	time, date en		d due to th	ne ceuse(s)	



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

								IOAII	- 01		* * * *		HEG. NO.			
		1. DECEDENT'S NAME (First,	, <i>Middle, Lasi)</i> Jargare	et Wats	:On			Ken	ned	77		2. DATI	-		YEAR 994	1:50 P M
		4. SOCIAL SECURITY NUMB		5. SEX		(In yrs. last	birthdayl	IF UNDER		IF UNDER	24 HRS	-	OF BIRTH			PLACE (State or Foreign
P		179-01-1468		1 🗆 M 2 🕁 F	93		YRS.	MONTHS	DAYS	HOURS	MIN.	NOV	713/190)1	Country	sylvania
3 should	_	9a. FACILITY NAME (If not in	-			. Ont				OR LOCATI	ON OF DE	EATH			ITY OF DI	
∾	DIRECTOR	Pleasant L	_	Convares	cent	. Cnt	r	EO	igew	ater				Ann	e Ar	undel
ges 1	ا <u>ښ</u>	10a. STATE	10b. COUNTY	,			10c. CIT	Y, TOWN (OR LOCA	TION	-					10d. INSIDE CITY LIMITS?
#; P3		Florida	Lee				For	rt My	ers	Beac	ch					1 TES 2 NO
physician. burial-transit permit. Pages 1,	FUNERAL	10e. STREET AND NUMBER								of. ZIP COD	E				ZEN OF W	HAT COUNTRY?
ian. transi	NE.	345 Peppard	Drive	2, Southw		4446 400		1	_	3931				USA		
physician. burial-trar		1 Never Married 2	Married	FORCES? 1	YES	2 XN			If yes, sp	pecify Cuba	ın, Mexica	in, Puarto	N? (Specify Yea Rican, etc.)	or No-	14. RACE American Indian, Black, White, etc.	
attending se as the	ВУ	3 Widowed 4 Divo	rced	11 123, 3172 1	with Off D	MIES			1 [] 1 [3	S 2 X NO	Specif	γ			Specif	white
	TED	15. DEC (Specify only	EDENT'S EDU	CATION completed)		(Gh	ve kind of v	USUAL O	CCUPATI during m	ION lost of working	ng	16	b. KINO OF BUS	INESS/IND	USTRY	
ortal or	IPLET	Elementary/Secondary (0)-12)	College (1-4 or 5	+)		Do NOT us		ne i	onera	tor	f	inancia	1/20	coun	ting
the hospital detached fo	COMPL	17. FATHER'S NAME (First, M	liddle, Last)			uddi	ing machine operator financial/account							cing		
8 E &	ш	John Watson					Not Available									
retained 1 5 should notified	TO B	19a. INFORMANT'S NAME (7	196	. MAILING	ADDRES	S (Street				nber, City or Town	n, State, Zip	Code)				
5 5	ř	Robert Kenn				_		sw	For				FL 33931			
age 6 may be director, page or must be		20a. METHOD OF DISPOSITION 1 Burlal 2 Cermation 3 Ramoval from Stala 4 Donation 5 Other (Specify)														
death. Pag funeral dir examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Advent Memorial Services, Inc.														
		- mela	ney	ulkeln	1	agi	her	4	2 Ht	udson	St	#A21	0 Anna	poli	s MD	21401
fours after d in by the or removal		23. PART i. Enter the di shock, or h	iseasea, or o eert feilure.	complications the List only one car	t cause use on e	d the dea	nth. Do r	not enter	the me	ode of dy	ing, suc	h ss ce	rdiec or reapi	retory err	est,	Approximate intervel Between
ine ine		iMMEDIATE CAUSE (Fir disease or condition	nel	<	. l	der	, C	and	ner	de	att	5				Onset and Death
ted within completely ial, cremat		resulting in death)		DUE TO	(OR AS	A CONSEC	UENCE O	F):,		/ `.		0	1.			
executed and com burial, natic ev	NO	Sequentially list conditi	ions.	b. 00	rero	sell	rot	me (an	aros	asc	ma	arsea	ef		10 years
ite be executivision and coprior to buris	CATION	immediate cause (finel disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injur										10 00000				
ertificate ing physi rgiene pr	FIC	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSEQUENCE OF):										10 700				
5 g x 8	ERTIFIC	reaulting in death) LAST														
the death y the attended Mental	L GE	PART ii. Other significa	int condition	a contributing to	deeth t	out not n	esultina	In the ur	nderivin	na ceuse	given in	Part i.	24a WAS AN	ALITOPSY	24h	WERE AUTOPSY FINDINGS
< g q g = 2	ICAL	Congest											art i. 24s. WAS AN AUTOPSY PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE
Sign Sign	MEDI	atrial	any	othmu									I U TES 2	ST NO	1	1 YES 2 NO
e law request bas been Dept. of 23 sho	 2	anemi	a of	chron	ie c	lice	asp									-
PHYSICIAN: The law requires certificate has been with the State Dept. of	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:				ОТНЕ		PLACE OF D	EATH (Ch	eck only o	one)			
CLAN: Sertific the Si	IXSI	1 YES 2 NO		1 Inputiant 2		petient 3		4 1 Nur	sing Hor	me 5 🗆 Re	esidence					
NG PHYS fter this c eath with marked,	ВУ РЕ	1 Netural 5	Pending Investigation	28a. DATE Of (Month, L		_	26b. TIM	JURY M	W	JURY AT ORK? YES 2	NO	28d. DE	SCRIBE HOW II	NJURY OC	CURED	
TTENDI TOR: A after d	<u>a</u>	3 Suicide 8	Could not be detarmined	28s. PLACE C building.	F INJURY atc. (Spe	Y — At her	me, ferm,	street, fac	tory, offic	ca			CATION (Street a or Town, State)	ind Number	or Rural F	Route Number,
1 4 2 E	COMPLET	nnel		CIAN: To the best of a) and menner as stated.
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 I	BE	29b. SIGNATURE AND TITLE	OF CERTIFIE	ermp			· ·			29c. LIC	ENSE NUI	MBER 7	7/	29d. OAT	E SIGNED	(Month, Day, Year)
F F 0 ==	5	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	SE OF O				1	ito 1	101	Ca	often	MO	21	1/4
		31. DATE FILEO (Month, Day,		32. REGISTRA		ATURE		- 4 67	120	/	<u> </u>		V - V- /			
		DEC (6 199	4 Julia	Much	works	volally									

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	nedio i nan		CERTIF	ICATE OF	DEATH	REG.	NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	A. WIS	EIN/			2. DATE OF DEAT		YEAR 3. TH	AE OF DEATH
	1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	-99	BIRTHPI ACE	(State or Foreign
Б		212-28-0580	1 D/4 2 D F	70 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Yes	24	Country)	10
pinous	~	9a. FACILITY NAME (If not institution, give str	reet and number)			OR LOCATION OF DI	ATH		Y OF DEATH	
1, 2, 3	СТОВ	RESIDENCE OF DECEDENT			TA	INAPOL	15		4.A	-
Pages	ш	10a. STATE 10b. COUNTY	^	10c. CIT	Y, TOWN OR LOCA					NSIDE CITY
permit. P	L DIR	7.0	T-A			NOW)				YES 2 NO
該	FUNERAL	325 CLIFT	on Are		10	H. ZIP CODE	2	10g. CITIZE	N OF WHAT C	OUNTRY?
5-0020 nding physician. is the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 3 YES IF YES, GIVE WAR OR D	2 NO	If yes, s	CENDENT OF HISPAI pecify Cuban, Maxica S 2 NO Specifi	n, Puerto Rican, etc.		A. RACE — Arr. Black, White Specify:	erican Indian, i, atc.
21 atte	LED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	18a. DECEDENT'S	USUAL OCCUPATI	ON CONTRACT WESTING	16b. KIND OF	BUSINESS/INDU	STRY	2
21 al or for u	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	WILB.	ERT A	KLER	1 ES!	DUA	DE	AN
A se s		17. FATHER'S NAME (First, Middle, Last)	O TALL			18. MOTHER'S NA	ME (First, Middle, Me	iden Sumame)	1-11	/
MARYI retained by 5 should be notified at	BE	190_INFORMANT'S HAME (Type/Print)	DEKIO	19b. MAILING	ADDRESS (Street	and Number or Rural	E COTT	France State Zin C	octa)	r
	5	Wrothea K	Tein	5	AME	TAS	#	10	000)	
AORE, pe 6 may be rector, page		20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val Irom State cer	PLACE AND DATE	ther pace)	eme of	DATE 200	STYUE	ty or Town, SM	e mo
BALTIMOF ter death. Page 6 m the funeral director, oval.	- 4	21. SIGNATURE OF FUNERAL MUNICE LICE	INSEE		22. NAME A	ND ADDRESS OF FA	0			
BALT ter death. the funera val. al examile		- Jours			BAR	DANGO	SAG			0
in by rem		23. PART i. Enter the diseases, or conshock, or heart feliure. L	in only one couse on e	the deeth. Do i ech line.	not enter the me	ode of dying, suc	h as cerdiec or r	eepiratory arrec		Approximete interval Between
E 8 €		IMMEDIATE CAUSE (Final disease or condition	Myor	12 20 8	. 0	I	2	٠	'	Onset and Death
3760, tted withing completely fille fal, cremation, event, the		resulting in deeth)	MYOC DUE TO (OR AS A Chron	CONSEQUENCE O	f):		Jave	41000		minutes
68760 xecuted with and comple burial, crea	S O	Sequentielly list conditions,	Chron.	<u> </u>	72842	uctive	· Kuln	no wary		Years
0 0	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):				i	
, P.O. BOX leath certificate be attending physician mtal Hygiene prior t y, or other trau	FI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				<u> </u>	
P. C. sath ce train Hydrical Hydron H	E	resulting in death) LAST	•							
DS DS		PART ii. Other eignificent conditions	contributing to deeth b	ut not resulting	in the underlyin	g ceuse given in	Part i. 24a. WA	S AN AUTOPSY		AUTOPSY FINDINGS
O H	EDICAL							FORMED? S 2 (MYNO		ABLE PRIOR TO LETION OF CAUSE ATH?
RECC requires seen signe of Health							_			rES 2 NO
AL RE he law requ has been be Dept. of h	N.	DID TOBACCO USE CONTR					1 🗆			
I OF VITAL RE PHYSICIAN: The law requ this certificate has been with the State Dept. of I inked, or Item 23 sho	PHYSICIAN: M	EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:					
SICIAL Sertif	HYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp. 28a. DATE OF INJURY	28b. TIM	E OF 28c. IN	JURY AT	8 Other (Specify) 28d. DESCRIBE HC	W INJURY OCCU	RED	
ON OF DING PHYS After this of death with s marked,	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO				
TISIC TTEND TTOR: A after d after d	ETED E	3 Suicide 6 Could not be detarmined	28s. PLACE OF INJURY building, stc. (Spec	— At home, larm,	street, factory, offic	Ca .	281. LOCATION (Sh City or Town, S	eet and Number or tate)	Rural Route No	imber,
DIV PITAL OR A RAL DIREC 1 72 hours 1 1f Item	COMPLE		IAN: To the best of my knowl							
FUNE FUNE Within	E CC	296. UGHATURE AND TITLE OF CENTIFIER				29c. LICENSE NUM			GIGNED (Month.	
TO THE HOSPITAL (TO THE FUNERAL DE fied within 72 h	TO BE	Jan S	linea-	> w	57	0169	661	> 1:		97
		30. MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type	Print)	2 V	id	2101	7	
	į	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE WELLOW ROAD	1 11					
		DEC 0.8.19	194 Juliada	nerec way	all .					

DALLIMORE, MARTLAND ZIZUS-3140	4 Jours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOA 13149,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fabra after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALTH AND	MENTAL HYG		
		oehre			2. DATE OF DEAT	ΠN	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. las	YRS. IF UNDE	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTI (Month, Day, Ye	N a.	BIRTNPLACE (State or Foreign Country)
e l	SIMAL HOSPITAL	and number)	9b. CIT	Y, TOWN OR LOCATION OF DE	-	9c. COUNTY	OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Λ	10c. CITY, TOWN	•			10d. INSIDE CITY LIMITS?
AL DI	100. STREET AND NUMBER	HRUNDEL	SEVE	101. ZIP CODE	<u>. </u>	10g. CITIZEN	1 VES 2 NO
FUNERAL		LUSEY DE	MED 13.	2/14 WAS DECENDENT OF NISPAL	C NIC ORIGIN? (Speed	1 US	RACE — American Indian,
E E	1 Never Merried 2 Merried 3 Widowed 4 Diverced	FORCES? 1 YES 2 N		If yes, specify Cubse, Mexics 1 YES 2 NO Specif	in, Puerto Rican, etc		Black, White, atc. Specify: WHITE
ETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)	npleted) (G	CEDENT'S USUAL (ive kind of work done . Do NOT use retired.)	during most of working	16b. KIND 0	F BUSINESS/INDUS	MA
COMPL	17. FATHER'S NAME (First, Middle, Last)	37 10	14 260	16. MOTNER'S N	WE First, Middle M	S/ LCS	O-
R	ANTON AUGUST	KOEHNE	h MAII ING ADDRES	S (Street and Number or Rural	BOUND NAMED OF COM	or Town State, Zio Co	DECK
2	ELLEN R. KOE	HVE	614CA	PE MCK	INSE	, DKS	EV 121146
	20s. METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	Batt	of disposition (lame of complety, crematory or	En	Ba 1-7	or Town, State
	21. SIGNATURE OF FUNCTORS SERVICE LICEN	SEE	22	NAME AND ADDRESS OF FA	W. 50	5 RITE	Ret Ms.
		plications that caused the det only one cause on each line		r the mode of dyling, suc	ch as cardiac or	respiratory stres	Approximata Interval Between Onset and Death
	immediate cause (Final disease or condition resulting in death)	Ceretal E	depo	Intercarel	hal be	morrhy	Conset and Death
Z	Sequentielly list conditions, 6	intercerba	al hen	norekage			2 weeks
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	fall (tran	vines				1 ments
CERTIFICATION	that initieted events resulting in death) LAST	DUE TO (OR THE A CONSE	QUENCE OF):				
4	PART II. Other algnificant conditions of	contributing to death but not	resulting in the u	inderlying cause given in		AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
PHYSICIAN: MEDIC	Hypertension				- Will	ES 2 NO	OF DEATH?
AN	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C		<i>be</i>	
200		OSPITAL:	DOA 4 N			(v)	
	27. MANNER OF DEATN 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	26d. DESCRIBE I	NOW INJURY OCCUI	RED
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street, fa	ctory, office	261. LOCATION (S City or Town,	Street and Number or State)	Rural Route Number,
COMPLETED	000)	N: To the best of my knowledge, do					
BE CO	206 SIGN UP AND TITLE OF CERTIFIER	2110	1 10	29c. LICENSE NU	MBER	29d. DATE 8	IGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	- 11-1	M 27) (Type, Print)	W 104 H 4579	1	1 -	12-5-99
	Dr. Einstein N 31. DATE FILED (Month, Day, Year)	1. 5 2401 32. REGISTRAR'S SIGNATURE	Wes	t Belie	eder/	Tre 2	2/215
	DEC 08 199		Rardall				

At the second of Tamakan ni indina Pina Nation Albania Andrew Salah Sal The second secon BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remonal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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										9	13	36980
1 - FOR STATE REGISTRAR	STATE OF M			TMENT (ENTAL	HYGIEN REG. NO			
1. DECEOENT'S NAME (First, Middle, Last)	RICHARD	MINEI	ELD	KIRE	ву я	SR.	2	DATE OF		2 c	YEAR	3. TIME OF DEATH 2:50 A.M
	5. SEX XX M 2 F	6. AGE (In yrs. last	t birthday) YRS.	IF UNDER 1 Y		IF UNDER 24	HRS. 7	Month,	Day Manel	5-22	6. BIRTI	IPLACE (State or Foreign
99. FACILITY NAME (If not institution, give street ANNE ARUNDEL M.		CENTER		9b. CITY, TO			OF DEAT		- 1,	9c. COU	NTY OF C	
ANNE ARUNDEL M. RESIDENCE OF DECEDENT 100. STATE MARYIAND	E ARUND	EL	10c. CITY		NA PULTS							10d. INSIDE CITY
	NECK B	OAD	[10f. Z	IP COOE	403			10g. CIT		WHAT COUNTRY?
Z	12. WAS DECEDENT FORCES? 1 [ω	If y	res, speci		HISPANIC Mexicen,		(Specify Yeen, etc.)	e or No—	14. RACI	S.A. E — American Indian, k, White, etc. AMERICAN
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 a) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INOUSTRY												
1. FATHER'S NAME (First, Middle, Last) CHARLES E. KIRBY 18. MOTHER'S NAME (First, Middle, Meiden Surname) SADIE DAVIS												
19a. INFORMANT'S NAME (Type/Print) GLORIA OFFER KIRBY 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10 E												
20. METHOD OF DISPOSITION 20. METHOD OF DISPOSITION 20. DATE 20. LOCATION - City of Town, State 20. LOCATION - City of Town, State 20. LOCATION - City of Town, State 20. LOCATION - City of Town, State 20. LOCATION - City of Town, State 21. SIGNATURE OF FUNERAL SERVICE LICENSEE CHARLES E. HICKS 20. LOCATION - City of Town, State ANNAPOLIS, MD. 214 ANNAPOLIS, MD. 2140												
23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, interval Battwe interval Battwe Onset and Da disease or condition resulting in death) Oue to (or as a consequence of):												
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEC	OUENCE OF	٦:								
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	contributing to c	leath but not n	esulting i	n the unde	erlying o	cause giv	ren in Pa	ort I. 2	4a. WAS AN PERFOI	RMED?	246	D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ poa	OTHER:		S () Rest	arres a ves	DESCRIPT-A	Sherifyi			
27. MARNER OF DEATH 1 Natural 5 Panding 2 Accident Investigation	26s. DATE OF I	(Moor)		E OF 26 URY M	WORK WORK T YES	TY AT	- 2	-	-	MJURY OC	CURED	
A Sudatata	building, e	BLURY — At hor tc. (Specify)						City or	Town, State,			Route Number
Check only												k) and manner as stated.
296. SIGNATURE(AND TUTLE OF CESTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Model), Day, Year) 12/4/94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CHAIN OTEN 37) (Soc. Date)												

ma)

DEC 08 1994

RICHARD
31. DATE FILED (Month, Day, Year)

BEC 08 1994

32. REGISTRAN'S SIGNATURE This Davidson Randall

DHMH-16 Rev 1/89

as the burial-transit permit, Pages 1, 2, 3 should

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SUNC	.5	or re	ned
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death, Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	(MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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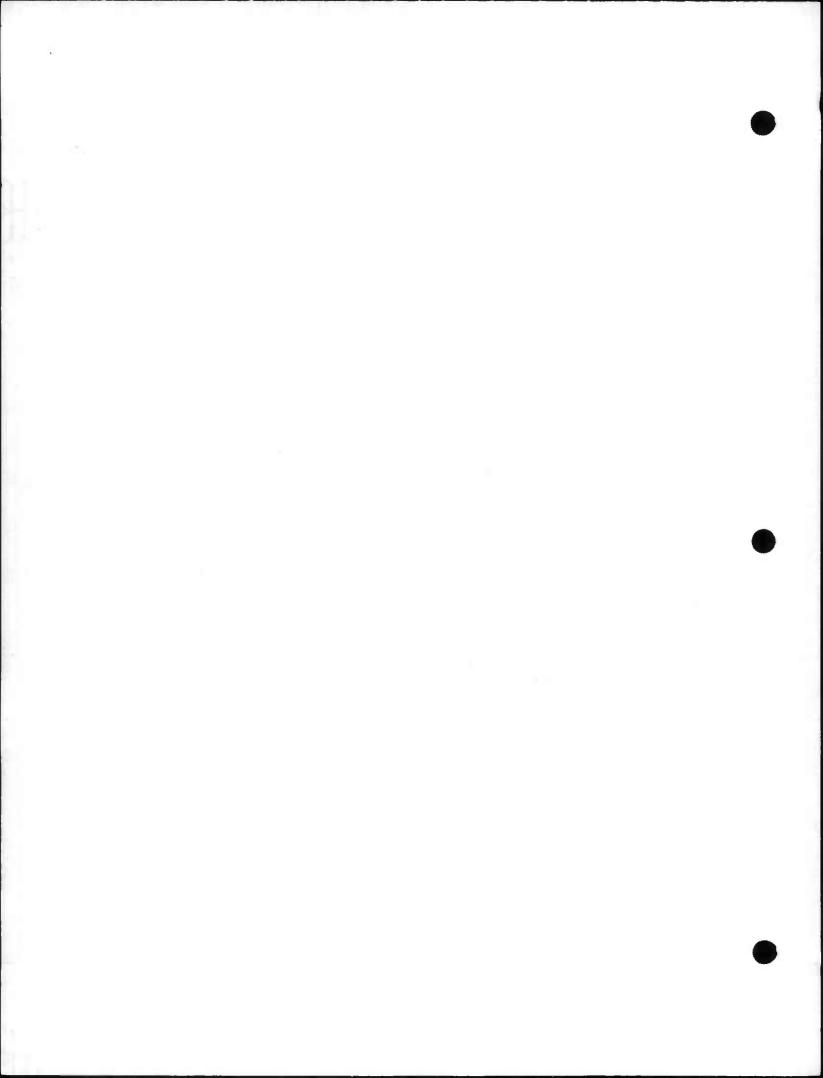
Amended #1 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE & CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH KELLY Helen Gertrude Nov. 25,1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthdey) UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year IF UNDER I YEAR 1 M 2 F DAYS 577-60-4466 90 June 23,1904 New York 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CARRIAGE HILL BETHESDA BETHESDA MONIGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 TYPES 2 NO Maryland Montgomery Bethesda FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6557 Broad Street 20816 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuben, Maxican, Puerlo Rican, atc.)

1 □ YES 2 ▼ NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried ВУ 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondary (0-12) State Department administrator 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) T. Eugene Kelly Rosalie Doux BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy Pyeatt 4242 East West Highway, Chevy Chase, Md. 20815 20a. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Donation 8 Other (Specify) Calvary Cemetery Nov.29,94 Utica, New York 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY
DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., D.C. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. Interval Batween **Onset and Death** IMMEDIATE CAUSE (Final Consetive Hont Films disease or condition ____ PHYSICIAN: MEDICAL CERTIFICATION ВУ COMPLETED

Sequentially list conditions, fany, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events eaulting in dasth) LAST	DUE TO (OR AS A CONSECUTION OF THE TO (OR AS A CONSECUTION OF THE TO (OR AS A CONSECUTION OF THE TO (OR AS A CONSECUTION OF THE TO (OR AS A CONSECUTION OF THE TO (OR AS A CONSECUTION OF THE TO (OR AS A CONSECUTION OF T	USSTYUCE WENCE OF: ACCTU	tris Pelm	ma, I	Disin	70
PART II. Other significant condition	a contributing to death but not re	eaulting in the u	ndariying cause given in		RMED?	24b, WERE AUTOPSY FINDINGS AMPLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
5. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	DOA 4 Nu	26. PLACE OF DEATH (C)			
7. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCU	RED
3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At hor building, atc. (Specify)	na, term, street, tac	tory, office	281. LOCATION (Street City or Town, State	end Number or)	Rural Route Number,
one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowledge, des R: On the bests of examination and/or in					
S W	who Me		29c. LICENSE NU	MBER 27	29d. DATE :	SIGNED (Mgnth, Day, Year)
B. Omha	O COMPLETED CAUSE OF DEATH (ITEM PU, MD 8805	(Type, Print)	Are, Che	Us Cherr	M	-20415
NOV 2 9 1994	32 REGISTRAR'S SIGNATURE FUNA DAVIDON-ROYK	tall				
es an a tan						DHMH-16 Rev 1/6

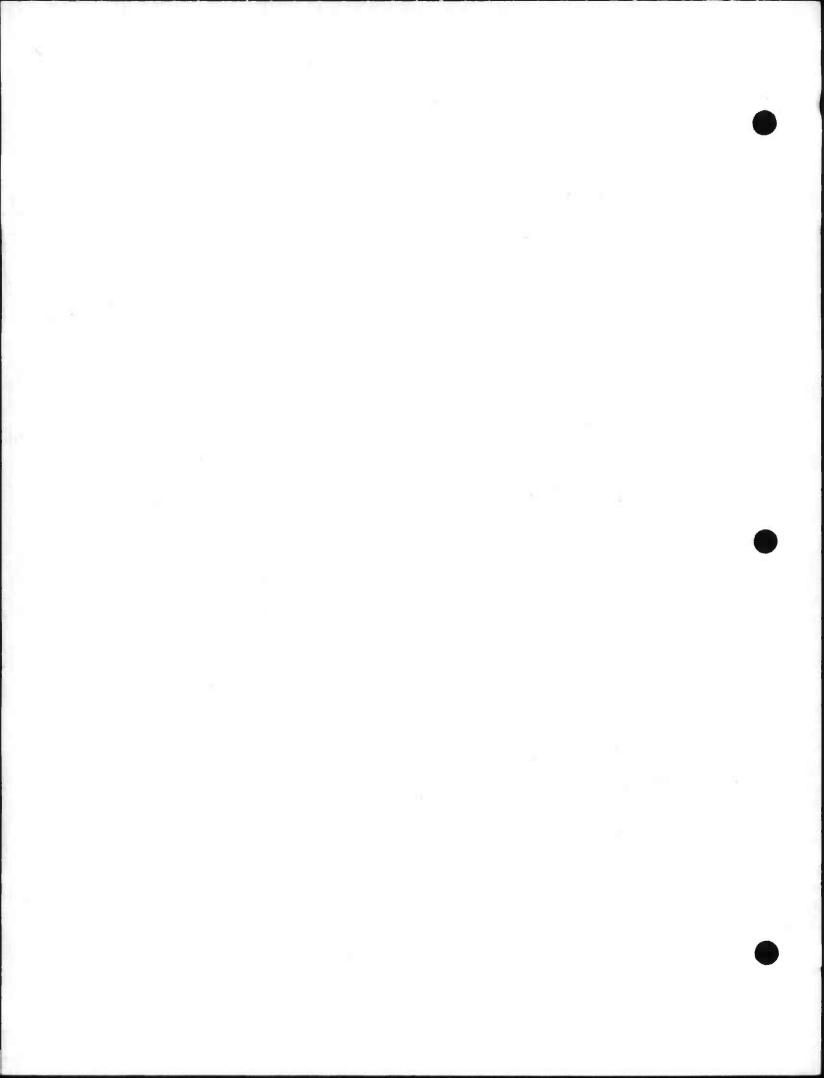
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7	Amended# 19b	- MRT	11/29	194 r	Montago	mer	2. Co. +		
	1 - FOR STATE OF STAT)F MARYLAND / DEP	PARTMENT OF	HEALTH AND N	MENTAL HYGIEN	E	y County		
	1. DECEDENT'S NAME (First, Middle, Last) SYIVA KNI'S		II TOATE O	DEATH	2. DATE OF DEATH		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 X 2	6. AGE (In yrs. last birthd	MONTHS DAVE	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 17,	1904	BIRTHPLACE (State or Foreign Country) New York		
ron	SHARON NUR.		96. CITY, TOWN	OR LOCATION OF DEA	ATH :		ntgomery		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c.	CITY, TOWN OR LOC	ATION			10d. INSIDE/CITY		
	MD Montgomer	у	Sandy Sp				LIMITS?		
FUNERAL	18202 Slade School Roa	ad		101. ZIP CODE 20832		United States			
BY FUN	1 Never Married 2 Married FORCES?	EDENT EVER IN U.S. ARMED 1 YES 2 X YOO VE WAR OR DATES	If yes,	ECENDENT OF HISPANI apecify Cuban, Maxican ES 2 NO Specify:			4. RACE — American Indian, Black, White, atc. Specify: White		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDEN	IT'S USUAL OCCUPA of work done during i	TION	16b. KIND OF BUS	SINESS/INDUS			
COMPLETED	X Elementary/Secondary (0-12) College (1-4	or 5+) Ilfe. Do NO	Bookkeepe		Schoha Coopera				
	17. FATHER'S NAME (First, Middle, Last) Frank E. Runkle			16. MOTHER'S NAM	AE (First, Middle, Maiden a Mann	Surneme)			
TO BE	190. INFORMANT'S NAME (Type/Print) Franklin Kniskern				oute Number, City or Tow Je, Silver				
20e. METHOD OF DISPOSITION 1 St Buriel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION/Neme of 11/30/94 20c. LOCATION - City or Town, State Cemetery, cremetory or other place) Cobleskill Rural Cemetery Cobleskill, NY 21. SIGNATURE OF USERAL SERVICE LICENSEE 20c. LOCATION - City or Town, State Cemetery Cobleskill, NY 11/30/94 Cobleskill, NY 12. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home									
	23. PART I. Entar tha diseases, or complications abook, or heart failure. List only one IMMEDIATE CAUSE (Final disease or condition resulting in death)	that caused tha death. Dicause on each line.	. 00				Interval Between Onset and Death		
N	- hu	erten.	E OF):				Jus		
CATIC	Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING	TO (OR AS A CONSEQUENCE	E OF):						
ERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	E TO (OR AS A CONSEQUENCE	E OF):						
O	PART Ji. Other significant conditions contributing	g to death but not resulting	ng in the underlyi	ng cause given in F	Part I. 24s. WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICAL	hypothyroidio				PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
 M	,				-		1 TYES 2 NO		
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL	:	26.	PLACE OF DEATH (Chec	ck only one)				
HYS	and the state of t	2 ER/Outpatient 3 DO/ E OF INJURY 26b.	A 4 Vursing Ho	me 5 Rasidence 6	Other (Specify) 26d. DESCRIBE HOW II	HIBY OCCU	eco.		
ВУ Р			INJURY V	YES 2 NO	200. DEJONISE NOW II	NONT OCCO	neu		
	3 Suicide a Could and by 26a, PLA	CE OF INJURY — At home, tarrifling, atc. (Specify)	m, street, factory, off	Ica	26f. LOCATION (Street a City or Town, State)	ind Number or	Rural Route Number,		
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis								
BE CC	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUME			HGNED (Month, Day, Year)		
TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED	F PHYSICIA	N	D420	046	▶ [1.	. 27 .94		
	G. BROOKE GO BLOI	DKE GROVE	FND 18	100 MAK	DEN OL	NEY,	HD 20832		
	31. DATE FILED (Month, Day, Year) NOV 2 9 1994 July	strabis signature Lawidson-Randal	82						

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	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)			CERTIF	ICATE (OF DEATH	REG. N	0.	1.	TIME OF DEAT				
	GAIL EUGENE KING						MONTH	DAY	YEAR					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS		28	1994 1	CE (State or Fo				
	275-46-1102	1 X M 2 - F	45	YRS.	MONTHS DA	YS HOURS MIN.	DEC. 17,	948	OREGO	ON				
	9a. FACILITY NAME (If not institution, give s				9b. CITY, TO	WN OR LOCATION OF			UNTY OF DEAT					
OR	NIH, THE CLINICA	L CENTER			BETH	ESDA, MAR	YLAND	MON	NTGOMER	RY				
ECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OR LO	OCATION			10	d. INSIDE CIT				
DIRECTOR	GEORGIA De	kalb De	· Kall		LANTA	A 1 1	nta			LIMITS?				
	10e. STREET AND NUMBER		-1(4)			10f. ZIP CODE		10g. Cl	TIZEN OF WHA					
FUNERAL	1779 MORRIS LAND	ERS DRIV	E			3034	5	l	J.S.A.					
5	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1					ANIC ORIGIN? (Specify		14. RACE -	American Indi				
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆	YES 2 NO Spe	can, Puerto Rican, etc.) city:		HITE					
	15. DECEDENT'S EDU	U.S. Pu			USUAL OCCUI	PATION	16b. KIND OF BUSINESS/INDUSTRY							
ETED	(Specify only highest grade Elementary/Secondary (0-12)			(Give kind of life. Do NOT u	work done during	g most of working	IOG. KIND OF BUSINESS/INDUSTRY							
P	Little Hally Controlly (C-12)	5+		hysici	.an		U.S. F	Public	Healt	th Ser				
COMPL	17. FATHER'S NAME (First, Middle, Last)					1a. MOTHER'S	NAME (First, Middle, Mald	en Sumame)						
BE (HUGH M. KING					VIOLA	ZEHR							
0	19a. INFORMANT'S NAME (Type/Print)						al Route Number, City or 1	own, State, Z	(ip Code)	-				
	CARLA SYVERSON				E AS A									
	20a. METHOD OF DISPOSITION 1									State				
	21. SIGNATURE OF FUNERAL SERVICE LIK	CENSEE /	1 Ball	niore-w	22. NAM	E AND ADDRESS OF	FACILITY		טוא					
	1 1/1/	0/1		and the Control of	Rapp	Funeral	Services,							
_	23 DAGT I Enter the discourse of	u	- Latinate American	0827			Silver S			20910				
1	23. Part I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final													
	IMMEDIATE CAUSE (Final disease or condition partition in death)									Onset and				
	resulting in death)							_		> ///				
z	PHENTINE (VITAL) (Alewviras)													
OIT	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):												
2	CAUSE (Disesse or injury	c. Ism new crupe win of from the to (or as a consequence of):							773	54				
RTIFI	that initiated avents reaulting in death) LAST	DOE 10	(OH AS A CON	SECUENCE O	F):	,	por 1)	ilal						
CEI		d								-				
4	PART II. Other significant condition	na contributing to	death but no	44.	11111	lying cause given		AN AUTOPSY		RE AUTOPSY F				
4	CML Justica	Myce	Just 1	1, pre	177/4	MYPION.	4 1 YYES	2 🗌 NO	CC	MPLETION OF DEATH?				
DICAL	the unito	illia,	Awe	MM	イナ				1	YES 2				
MEDICA	DID TOBACCO USE	CONTRIBUTE	TO CA	USE OF	DEATH	YES N	0 🗆 📗							
N: ME	25. WAS CASE REFERRED TO MEDICAL													
ICIAN: ME	EXAMINEST?	HOSPITAL:	EXAMINENT 1 YES 2 TO THER: 1 Inpetient 2 GENOutpetient 3 DOA 4 Mursting Home 5 GResidence 8 DOther (Specify)											
YSICIAN: ME	1 TES 2 TO	1 Inpetient 2 C		-			28s. DATE OF INJURY 28s. TIME OF 28s. INJURY AT 28st. DESCRIBE HOW INJURY WORK?							
ICIAN: ME	EXAMINERY TO THE TENT OF DEATH 1 Netural S Pending	26s. DATE OF	INJURY	28b. TIN	E OF 28c	INJURY AT WORK?	284. DESCRIBE HO							
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MPLETED BY PHYSICIAN: ME	EXAMINER OF DEATH 1 YES 2 TO 27. MANNER OF DEATH 1 Natural S Pending investigation 2 Accident S Could not be determined 29a. CERTIFIER (Check only 1) CERTIFYING PMYS.	26s. DATE OF (Mowh, D. 28s. PLACE Of building.	INJURY oy. Warri F INJURY — Ar stc. (Specify) my knowledge.	28b. TIN 84, t home, farm,	E OF 29c NURY 1 street, factory.	INJURY AT WORK? VES 2 NO office date and place, and d	28f. LOCATION (She	narvner as et	atled.					
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301 GEORGIA AVENUE - SILVER SPRING, MD

3. TIME OF DEATH

1) 28 Am

REG. NO.

2. DATE OF DEATH MONTH

	m	4. SOCIAL SECURITY NUM	a A	O stl	AGE (In yrs. ie	of birthday) IF U	NDER 1 YEA	AR IF UNDER 24 HRS.	7. DATE OF BIRT	ale C	YEAR 1 28 Am BIRTHPLACE (Sudio or Foreign		
		164-10-0031	1	□ M 2 💢 F	8:	MONT	-		July 4.	ear)	Country)		
2, 3 should	TOR	90. FACILITY NAME (# not in Holy Cross	Hospita.					r Spring		9c. COUNT	y of DEATH		
Pages 1.	DIRECTOR	10a. STATE	10b. COUNTY			10c. CITY, TOV	VN OR LO	CATION			10d. INSIDE CITY LIMITS?		
		Maryland	Montgo	nery		Silve	r Sp				1 YES 2 NO		
it permit.	ERAL	100. STREET AND NUMBER		rd Uant	A - A	#2020		10f. ZIP CODE			EN OF WHAT COUNTRY?		
215-0020 attending physician. se as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Div] Married	2. WAS DECEDENT EV. FORCES? 1 1 1	ER IN U.S. AI	RMED	If yes	20902 DECENDENT OF HISPA , specify Cuben, Maxic YES 2 NO Speci	an, Puerto Rican, et	Ify Yes or No- 1	d. RACE — American Indian, Black, Whita, etc. Specify: White		
D 21 pital or ed for u	APLETED		CEDENT'S EDUCAT thy highest grade cos (0-12)		III	ECEDENT'S USUA We kind of work do Do NOT use retin	one during ed.)		16b. KIND OF BUSINESS/INDUSTRY				
AND the hospit detached		17. FATHER'S NAME (First, A	Hiddle, Last)				MI I	18, MOTHER'S N.	AME (First, Middle, A				
- 5 5 W	BE	Edel Katz Mindel Katz 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code)											
Z 5 5	2	Eugene Korth (Son) 10241 Colebrook Ave. Potomac, Md. 20854											
BALTIMORE, after death. Page 6 may be by the funeral director, page noval.		20a. METHOD OF DISPOSIT 1 X Burlet 2 Cremett 4 Donation 5 Other	TION on 3 - Ramova		20b. PLACE	AND DATE OF DIS	POSITION	(Name of	DATE 2	c. LOCATION — CI			
		21. SIGNATURE OF FUNER	AL SERVICE LICEN	SEE			22. NAMI	E AND ADDRESS OF FA	ACILITY				
		10 Tol	en S	Low	mer		1170	nzansky-Go Nockvill	oldberg I	Memorial Rockwill	Chapels, Inc.		
within hours pletely filed in the cremation, or referred, the media		23. PART I. Enter the cahock, or I IMMEDIATE CAUSE (FI disease or condition resulting in death)	neart fallure. Lis	nplications that cause of the court only one cause of the court of the			nter the	mode of dyling, au	ch as cardiac or	reapiratory arred	at, Approximate interval Batween Onset and Daath		
P.O. BOX 68 th certificate be executed physician and I Hygiene prior to bur or other traumatik	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
RECORDS, requires that the deal signed by the att of Health and Menta shows any injury,	MEDICAL C	PART II. Other algorific	ant conditions	contributing to dea	th but not	requiting in the	a underi	ying cause given in	PI	AS AN AUTOPSY ERFORMED? 'ES 2 NO	24b. WERE AUTOPBY FINDINGS AMBLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	PHYSICIAN	25. WAS CASE REFERRED EXAMINER?						. PLACE OF DEATH (C	heck only one)				
F VITA SICIAN: The certificate in the State I, or Item	YSIG	1 TES 2 NO		OSPITAL:		DOA 4	_	Home 5 - Residence					
O FF state of	ву Рн	27. MANNER OF DEATH 1 Natural 5 2 Accident	Pending Investigation	28a. DATE OF INJU		28b, TIME OF INJURY		INJURY AT WORK?	26d. DEŞCRIBE	HOW INJURY OCCU	REO		
DIVISION DR ATTENDING DIRECTOR: After hours after death Nem 28 is man	ETED !	3 Suicide 6 4 Homicide	Could not be determined	28s. PLACE OF IN. building, etc.	JURY — At he (Specify)	oma, farm, street,	factory, o	offica	281. LOCATION (: City or Town,	Street and Number of State)	r Rural Route Number,		
DI DIR	립	one)						date and place, and du			i. cause(a) and manner as stated.		
TO THE HOSPITA TO THE FUNERA Be filed within 7	BE	295. SIGNATURE AND TITL	E OF CERTIFIER	20110	111	18	7	29c. LICENSE NU	MBER 7012	29d. DATE	SIGNED (Month, Day, Year)		
223	오	30. NAME AND ADDRESS O	OF MERSON WHO	COMPLETED CAUSE O	F OEATH (ITE	M 27) 17/00, PM	8		X	,	Vacuty-		

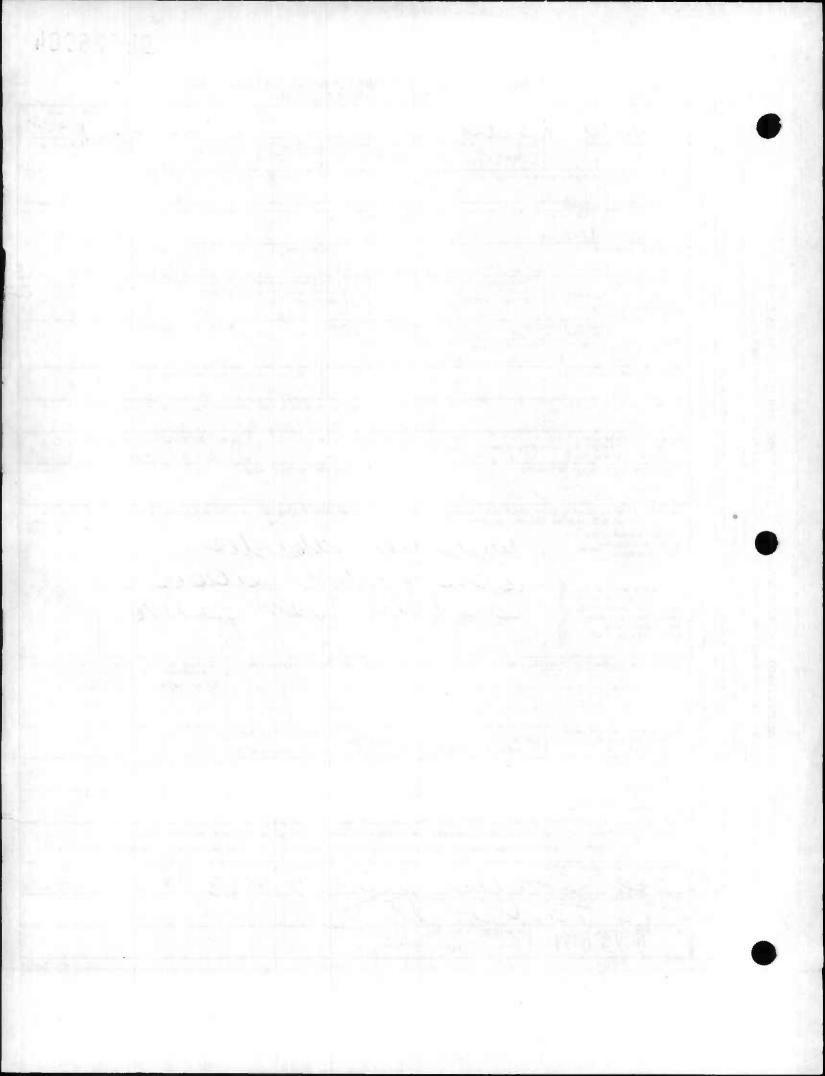
Suka Davidson-Randalle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DHMH-16 Rav 1/89



BALTIMORE, MARYLAND 21215-0020

BOX 68760.

DIVISION OF VITAL RECORDS, P.O. TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 ho

permit. Pages 1, 2, 3 should lage 6 may be retained by the hospital or attending physician. director, page 5 should be detached for use as the burial-transit F notified after death. Page 6 may be Pe must examiner filled in by the fion, or removal. medical the cremation. completely event, executed within burial, other traumatic and attending physician a 2 The law requires that the death certificate 0 signed by the atter Health and Mental any Injury. shows a peen Dept. certificate has b ltem. HOSPITAL OR ATTENDING PHYSICIAN: 0 the this c marked,

DIRECTOR

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CERTIFICATION

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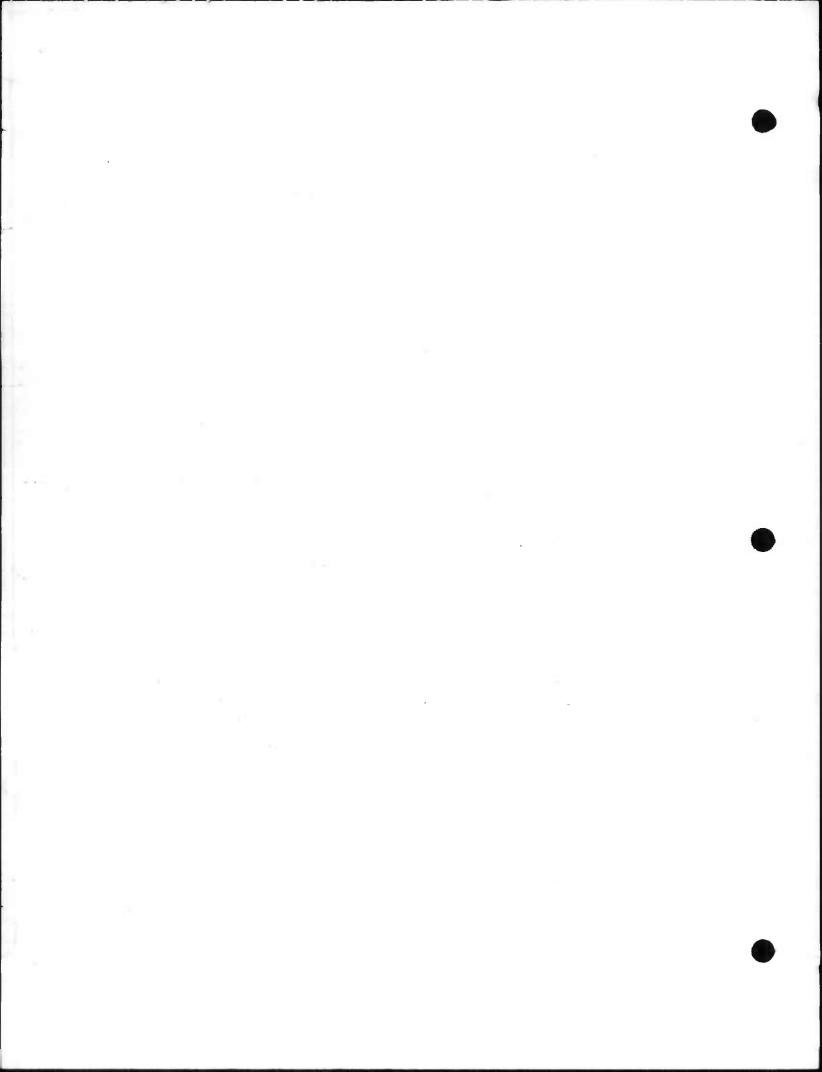
DIRECTOR: After the hours after death vitem 28 is mari

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH November 29, 1994 Bertha Lillian Kilian 12:10 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1925 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 1 M 2 F 203-12-4913 69 VRS February 14, Pennsylvania 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Wheaton X YES 2 NO 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14037 Breeze Hill Lane 20906 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 It yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify 3 X Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION

Work done during most of working 15. DECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INOUSTRY (Specify only highest grade completed) (Give kind of work done Elementary/Secondary (0-12) Coffege (1-4 or 5 +) 12 Administrative Secretary Medical 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Nicola Mazzotta Sylvia Cavalieri 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene O'Connor 14037 Breeze Hill Lane Wheaton, Maryland 20906 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 1 Buriel 2 Coremetion 3 Re 4 Donation 5 Other (Specify) Metropolitan Crematory 11/30/94 Alexandria, Virginia 21. SIGNATURE OFFUNERAL SERVICE LIGHNEE 22. NAME AND ADORESS OF FACILITY
Francis J. Collins Funeral Home, Inc. HA 500 University Blvd., W. Sil. Spr., MD 20901 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate ahock, or heart failure. Liet only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease Dr Condition Cerchon Inspiret resulting in death) OUE TO (OR AS A CONSEQUENCE OF): Cerebro-VALVIAT discore Sequentially liet conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not recuiting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Hypertansica Obst AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 TYES 2 NO Chronic Obstrata Line Discore 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO patient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 28e, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Natural INJURY 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, tarm, street, factory, offica building, atc. (Specify) 3 Sulcida 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(e) and menner ee stated. 256. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

H41818 11-29 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM, 27) (Type, Print) Silver Spra 50 ite 150 MD. Sterling 12520 Brosperity Dr. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE whia Davidson Randall 1994 1



BALTIMORE, MARYLAND 21215-0020

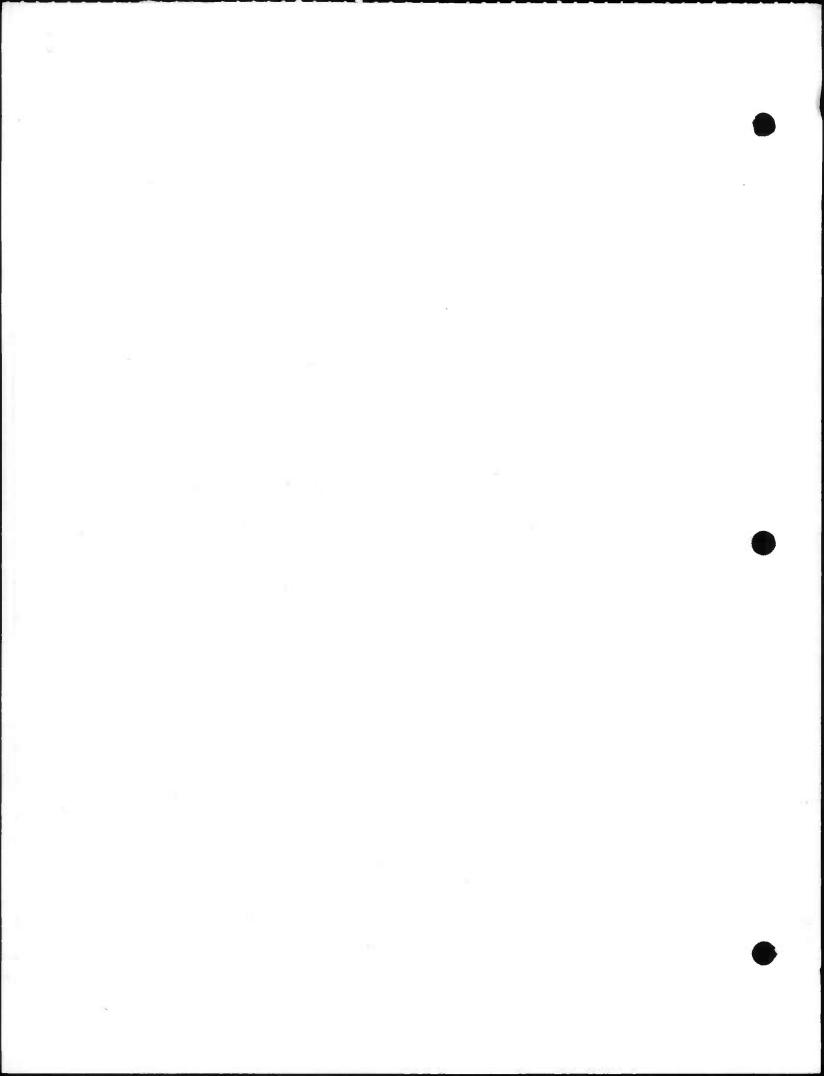
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the form of the feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
- 1	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
DIRECTOR	Stephen James Kane				November 2	7. 1994	8:00 PM	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AG		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign	
	217-68-6009 1 X M 2 F 9a. FACILITY NAME (If not institution, give street and number)	39 YRS.	DAYS DAYS	HOURS MIN.	(Month, Day, Year) May 15, 19	55 Wash	ington State	
EC	10a. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATI	ON			10d. INSIDE CITY	
FUNERAL DIF	Maryland Montgomery	Si	lver Sp	ring			LIMITS?	
	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?		
	1806 Merrifields Drive			20906		τ	U.S.A.	
5	11. MARITAL STATUS 1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Never Merried 2 Merried		13. WAS DECENDENT OF HISPANIC ORIGIN? (Spill yea, specify Cuban, Mexican, Puerto Rican,		IIC ORIGIN? (Specify Yes	or No- 14. RAC	E — American Indian,	
ВҰ	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES		1 ☐ YES 2 📉 NO Specify:			Spec	otty:	
COMPLETED	15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION			White N 166. KIND OF BUSINESS/INDUSTRY				
			done during mos	ne during most of working		30011120071110031111		
립	12	Business Manager			Electronics			
Ö	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER:			18. MOTHER'S NA	IAME (First, Middle, Maiden Sumame)			
BE (George Patrick Kane				Marriane Redmond			
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of				20000			
	George Patrick Kane				e Silver			
	1 LX Buriet 2 U Cremation 3 Removat from State	Ob. PLACE AND DATE OF Commetery, crematory or other	nlecel			CATION — City or T	CONTRACTOR OF THE PROPERTY OF	
	4 Donation 5 Other (Specify) Gate of Heaven Cemetery 11/30/94 Silver Spring, Marylan 21. SIGNATURE OF FULL TY 22. NAME AND ADDRESS OF FACILITY							
	MANAGEN DOCTOR				llins Fune	ral Home	, Inc.	
	Manew L. Cole		500 U	niversit	y Blvd.,W.	Sil.Spr		
ı	23. PART i. Enter the diseases, or complications that caus ahock, or heart failure. List only one cause on	each line.	enter tha mod	le of dying, suci	h ss cerdiac or respi	retory errest,	Approximsta Intarval Between	
	IMMEDIATE CAUSE (Fine) disease or condition						Onset and Death	
CERTIFICATION	resulting in death) a. CESPIRITION TREES OUE TO (OR AS A CONSEQUENCE OF):				(3 Minute	
	disease or condition resulting in death) a. VESPIRATORY ARREST Sometime of the second of the secon							
	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):						10/0/11	
S	Cause. Enter UNDERLYING CAUSE (Disease or Injury	c						
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST							
H	d							
AL.	PART ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PINDINGS PERFORMED?							
	7						COMPLETION OF CAUSE	
PHYSICIAN: MEDIC					_		1 TES 2 NO	
ÿ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:							
ΥS	1 YES 2 NO 1 Inpatient 2 ER/Ou 27. MANNES OF DEATH 28e. DATE OF INJURY	rtpatient 3 DOA 4	☐ Nursing Home		6 Other (Specify)			
	1 Natural 5 Pending (Month, Day, Year)		Y WOF	IRY AT IK? ES 2 \cap NO	28d. DESCRIBE HOW IN	HJURY OCCURED		
B	2 Accident Investigation 3 Suicide 8 Could get be 28s. PLACE OF INJUI	RY — At home, tarm, stre		2 7 10	281 LOCATION (Street a	and Number or Rumi	Doubs Number	
COMPLETED	3 Suicide 8 Could not be detained 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28t, LOCATION (Street and Number or Rural Route Number, City or Town, State)			
۳ ا	29a. CERTIFIER (Check only (Check only) (Che							
MP	(Check only one) 1 In CERTIFFING PRYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated, one) 2 MEDICAL EXAMINER: On the beate of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.							
	TOP CLONOTINE AND THE OF SECURITY							
BE	296. SIGNATURE AND MILE STEPPED (Month, Pay, Year)							
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
	TRA N. TUBLIN MD 8830 CAMERONST SILVOR SPRING, MD							
	31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE							
	NOV 3 0 1994 Julie Davidse	n-hanasac						



3. TIME OF DEATH

2. DATE OF DEATH DAY

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)
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	4. SOCIAL SECURITY NUM	IDEN	5. SEX	8. AGE (In y	s. last birthday)	IF UNDE	R 1 YEAR	IF UNDER 24	LHRS. 7. I	DATE OF BIRTH		a BIRTHRI	ACE (State or Foreign
	213-24-987		1 🗆 M 2 💢 F	68	YRS.	MONTHS	DAYS	7	MIN.	Month, Day, Year) CV. 17,1	.926	Country) MARY	
E	WAShington	Adver	ntreet end number)	. + R	ehab.		Y, TOWN C	PR LOCATION			9c. COUN	TY OF DEAT	mery
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DIRECTOR	MARYLAND	MONT	GOMERY			THER							d. INSIDE CITY LIMITS?
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	15. DEC (Specify onl	CEDENT'S EDU	CATION completed)	184	DECEDENT'S	work done	during mos	N et of working		16b. KINO OF B	USINESS/INDU	JSTRY	
COMPLET	Elementery/Secondary (I	(0-12)	College (1-4 or 5 +		HOMEMA	ise retired.)	Same mod	at to working		Н	OME		
3	17. FATNER'S NAME (First, M	Middle, Last)						18. MOTNE	R'S NAME (F	irat, Middle, Maide	n Sumeme)		
BE (VERNON	ETZLE	R				1	ETH	EL I	RENE	WARNE	?	
2	19e. INFORMANT'S NAME (-		19b, MAILING	ADDRES	S (Street ar	nd Number or		Number, City or To			
	ETHEL CA	MPBELL		201 01		_		ROAD		ATON, M		20906	
	1 K Burlel 2 ☐ Crematic 4 ☐ Donetion 5 ☐ Other	on 3 🗆 Rem r (Specify)			LORSVI	ther nace)	CHUR	CH C	EM. 1	2/1 TA	OCATION — C	TLLE.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE MURIEL H. BARBER FUNERAL HOME 20882 P. O. BOX 5038 LAYTONSVILLE, MARYLAND 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate.												
CERTIFICATION	resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, fi any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											YEAR	
	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDING AMALABLE PRIOR TO AMALABLE PRIOR TO												
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		condition					derlying	cadee giv	en in Part	i. 24a. WAS AI PERFO 1 — YES	RMED?	CO OF	RE AUTOPSY FINDING ALABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
	25. WAS CASE REFERRED TO									1 TYES	RMED?	CO OF	MABLE PRIOR TO MPLETION OF CAUSE DEATH?
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E COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF OEATN 1 Natural 5 1 2 Accident 3 Suicide 6 0 4 Nomicide 6 0 29e. CERTIFIER (Check only)	Pending Investigation Could not be datermined	HOSPITAL: 1 Inpatient 2 Inpati	NJURY y, Yeer) INJURY — Avitc. (Specify)	t 3 DOA 28b. TIM INJ t home, ferm, s	OTHEF 4 Num E OF JURY M street, fact	28. PLJ	ACE OF OEAT 5 Resid Resid 17 Resid 18 Resid 18 Resid 18 Resid 18 Resid 18 Resid 18 Resid 18 Resid 18 Resid	IN (Check on the control of the cont	PERFO 1 YES 1/ YES Dither (Specify) DESCRIBE NOW LOCATION (Street City or Yourn, State)	INJURY OCCU	AMP COOP OF 1 [INCOMPRED I Rural Route 1. Couse(e) and	NLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
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TO BE COMP	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF OEATN 1 Netural 5 1 2 Accident 3 Sulcide 6 0 4 Nomicide 29e. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE 30. NAME AND ADORESS OF	Pending Investigation Could not be datermined TIFYING PHYSIC ICAL EXAMINED F PERSON WNC	HOSPITAL: 1 Inpatient 2 28e. DATE OF (Month, Da 28e. PLACE OF building, of	INJURY — A INJURY — A Indic. (Specify) Try knowledge aminstion end E OF DEATN (28b. TIM INJ 28b. TIM INJ t home, ferm, of the occurre for investigation TEEM 27) (Type,	OTHER 4 Num 1E OF JURY M street, factored at the till	28. PLJ	ACE OF OEAT 5 Resid IRY AT 1K? ES 2 N	IN (Check on the control of the cont	PERFO 1 YES 1 YES Other (Specify) DESCRIBE NOW LOCATION (Street City or Yown, State cause(s) end ma date end place, e	INJURY OCCU	OO OF 1 [] I [I [MABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number, d manner ee stated.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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5-0020	anding physician.	as the burial-transit permit. Pages 1, 2, 3 should		
BALTIMORE, MARYLAND 21215-0020	ifter death. Page 6 may be retained by the hospital or att	/ the funeral director, page 5 should be detached for use loval.	al examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

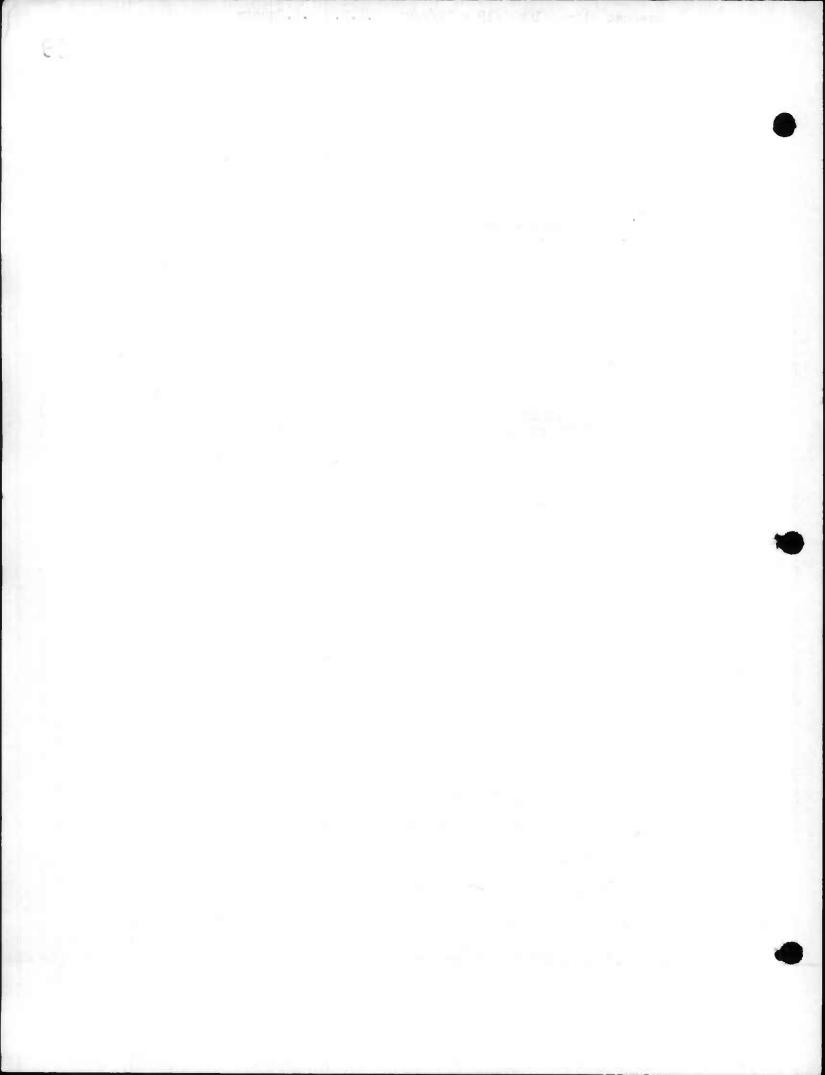
	FOR STATE REGISTRAR	STATE OF M			TMENT OF	HEALTH AND	MENTAL	HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) MICHAEL			WANSK			MONTH	OF DEATN	AY	YEAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE (8 BIRTHP	10:45 A.M
	094-01-2702	1 M 2 - F	75	YRS.	MONTHS DAYS	HOURS MIN.	(Month,	Day, Year) h 25,		Country)	York
~	9e. FACILITY NAME (If not institution, give s	street end number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY (ATN
DIRECTOR	Carriage Hill				Beth	esda			Mon	tgom	ery
Ä	10e. STATE 10b. COUNT	Υ		10c. CITT	, TOWN OR LOCA	TION					IOd. INSIDE CITY
		ntgomery	Bet	hesda						LIMITS?	
FUNERAL	10e. STREET AND NUMBER				10	H. ZIP CODE					AT COUNTRY?
W.	5900 Carlton Lane			Total Control		20816			U.S		
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS OECEDENT FORCES? 1 S IF YES, GIVE WI W.W.11	YES 2	RMED NO	If yes, s	CENDENT OF NISPAR pecify Cuben, Mexice S 2 XNO Specify	n, Puerto R		s or No—		
입	15. DECEDENT'S EDU (Specify only highest grade	CATION			USUAL OCCUPAT		16b.	KIND OF BUS	SINESS/INDL		
COMPLETED	Elementary/Secondery (0-12)	College (1-4 or 5+)	lik	e. Do NOT us							
₽	12		m	eat d	epartme	,		& P :			
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			Surneme)		
B	Philip Kowansky 190. INFORMANT'S NAME (Type/Print)						Karp				
임	Adelaide V. Kowa	ansky				and Number or Rural					
- 1	20e. METHOD OF DISPOSITION 1 Deputies 2 Cremetion 3 Rem	auni from State	20b. PLACE	ANDDATEC	F DISPOSITION /A	teme of	DATE	20c. LO	CATION — C	atty or Tow	n, State
	4 Donation 6 Other (Specify)	TOTAL TOTAL STATE	Quant	ico N	ational	Cem.,De	c.1,9	4 Tr	iang1	e, V	irginia
	21, SIGNATURE OF FUNERAL SERVICE LIC	CENSEE ON	1		22. NAME A	ND ADDRESS OF FA	CILITY				
	Danies 8	18/11				<pre>1 Funera: Wiscons:</pre>			u ua	ch I	OC 20007
CERTIFICATION	shock, or heart failure. List only one cause on aach lina. iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									Onset and Daath	
	PART II. Other significant condition	ne contributing to	death but not	reculting i	n the condensated	a course alves to	Dom I. I			1	
PHYSICIAN: MEDICAL					ii the diluariyii	ig causa givan in	Part I.	24a. WAS AN PERFOR	RMED?		WERE AUTOPSY FINDINGS WALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO
ÿ											
Ž	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. F	LACE OF DEATH (Ch	neck only one	9)			
ı X	1 ☐ YES 2 ★NO 27. MANNER OF DEATH	1 Inpetient 2 I		-	4 🔀 Nursing No	me 5 - Residence					
BY P	1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF I (Month, Da	y, Year)		M 1 🗆	JURY AT ORK? YES 2 NO	28d. DES	CRIBE HOW I	NJURY OCC	URED	
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF building, e	INJURY — At hote. (Specify)	ome, ferm, s	treet, fectory, offi	ce		ATION (Street or Town, Stelle)		or Rural Ro	ute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI CONTROL OF CONT	ICIAN: To the best of r									end menner es stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	estan 1	MS.			29c. LICENSE NUI					Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WH										,
	James F. Mackin,	M.D., 540)1 West	ern A	ve.,N.W	.,Washing	gton,	D.C. 2	20016		
	NOV 2 9 1994	32. MEGISTRAS	widoon-R								·
	de me e ann				0.00						DUMBLE OF Day 1/20

physician. e burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

is after death. Page 6 may be retained by the hospital or attending	 by the funeral director, page 5 should be detached for use as the removal. 	dies avaminar must be notified of ones
Suno	lled in	-
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a jours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	sespectant. It have 20 to morked or them 22 shows one inter or other from male average average and process
G PHYSICIAN	er this certification with the S	as hadee
OR ATTENDIN	MRECTOR: Aft nurs after dea	a of 90 mm
THE HOSPITAL (THE FUNERAL D	DODTANT. 16 10.
2	23	

	1 - FOR STATE REGISTRAR	STATE OF MARY			OF HEALTH		ENTAL HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Last) Pearl Kelle	у				2	DATE OF DEATH	YEAR	3. TIME OF DEATH 5:30 n M		
	4. SOCIAL SECURITY NUMBER 578-32-8242A	8. SEX 6. AG	83 YRS	MONTHS	1 YEAR IF UNDER DAYS HOURS	24 NRS. 7	Month Day, Year)	e. BIF	THPLACE (State or Foreign Intry). Shington, D.C.		
TOR	Fox Chase Nursing				ver Spri		TH	9c. COUNTY OF DEATH Montgomery			
DIRECTOR	100. STATE 100. COUNTY	Montgomery		lver S	Spring			10d. INSIDE (LIMITS?			
	10e. STREET AND NUMBER				10f. ZIP CODE 2090				F WHAT COUNTRY?		
FUNERAL	11. MARITAL STATUS						ORIGIN? (Specify Yee	or No.— 14. R/	ACE — American Indian, ack, White, atc.		
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YE	DATES T	1	yes, specify Cube		Puerto Hican, etc.)		Black		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	Cation completed) College (1-4 or 5 +)	We. Do NO	of work done d T use retired.)	luring most of working	ng	186. KIND OF BUSI				
OMF!	Seconary-12th 17. FATHER'S NAME (First, Middle, Last)		Reales	state 1		HER'S NAME	(First, Middle, Meiden S	Estate/	Sett		
BE C	Luther Williams	3					Colliver W	,	3		
TO B	TO INFORMANTIO MANE CO-CO-	Cousin	19b. MAILI	ING ADDRESS			ite Number, City or Town				
F	Earl Tolliver /Go	nison	0690				ve Stanfo				
	20a. METHOD OF DISPOSITION 1. Burlel 2 Cremetion 3 Rem 41. Donation 8 Other (Specify)	oval from State	other place) Gate Of	Heave	en Cemet	erv	Silv	er Spri			
	21. SIGNATURE OF FUNERAL SERVICE LI	Quantos M.	ORTUA	R. Y 22.1	NAME AND ADDRES	SS OF FACIL	4906 Iv		Place		
	23. PART I. Enter the diseases, Drenock	List only one cause or	sed the death. D	o not antar		Appl Control		0748 story arrest,	Approximate Interval Batween Onset end Death		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
AL C	PART II. Other eignificant condition	ns contributing to deat	h but not resultin	ng in the un	derlying ceuse (given in Pa	ert i. 24a. WAS AN /		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
PHYSICIAN: MEDIC							1 TES 2		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
IAN	25. WAS CASE REFERRED TO MEDICAL				26. PLACE OF D	EATH (Check	k only one)				
SIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/C	Outpetlent 3 🗆 DO/	4 Divini	t: sing Home 5 □ Re	eeldence 8	☐ Other (Specify)				
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28e. DATE OF INJUI (Month, Day, Yea	28b.	TIME OF INJURY M	28c. INJURY AT WORK?		esd. DESCRIBE HOW IN	JURY OCCURED			
B	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJU building, etc. (S		m, street, facto	ory, office	2	281. LOCATION (Street at City or Town, State)	nd Number or Rui	ral Route Number,		
COMPLET	TOTIOCK OTTY	ICIAN: To the best of my kr							se(e) and manner ea stated.		
TO BE C	29b. SIGNATURE ONLY	12	18/	K,	My 290-LIC	O //	20	29d. DATE SIGN	NED (Month, Day, Year) -02-94		
	WALTER E GO. 31. DATE FILED (Month, Day, Year)	DZH, M	2309	SHO	REFIL	LDA	RD, WH	EATON	u, md 20902		
	OF CO 9 1994	32. REGISTRAR'S S	son-Randal	2							
	DEOG	U							DHMH-16 Rev 1/89		



BALTIMORE,
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D. BOX
3S, P.(
'ITAL RECORDS, P.O. BOX 68760,
TAL E

DIVISION OF V

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (Firs	t, Middle, Last)								2. DATE	OF DEATH		T	3. TIME OF DEATH
				Edna	Ε.	Kit	e				Dec	- 44	1994	YEAR	8:30 AM M
		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER		IF UNDE	7	7. DATE	OF BIRTH		B. BIRTHP	LACE (State or Foreign
-		188 36 378:	3	1 - M 2 - F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	Dec	. 4 19	05	Penn	sylvania
should	_	Se. FACILITY NAME (# not i	_				9b. CITY	, TOWN	OR LOCAT	ION OF D	EATH	TH 9c. COUNTY OF DEATH			
2,3	CTOR	Doctors' C		ity Hospi	tal		La	nhan	n			Prince George's			George's
Pages 1	REC	10a. STATE	10b. COUNT	TY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?	
5	ā	Maryland		ce George	e's	В	owie								NX YES 2 □ NO
permit.	RAL	10e. STREET AND NUMBER				10f. ZIP CODE							10g. CITIZ	EN OF WI	HAT COUNTRY?
020 physician. burfal-transit	FUNE	16107 At	udubon						207						tates
020 ohysici burfal	교	1 Never Married 2	Merried		NT EVER IN U.S. A 1 YES 2 WAR OR DATES			If yes, sp	ecify Cubi	an, Mexic	an, Puerto	V? (Specify Yes Rican, etc.)	or No-	Black,	- American Indian, White, etc.
215-0020 attending physician. se as the burial-tran	BY	3 KWidowed 4 □ Div	orced	IF TES, GIVE	WAR OR DATES	No		I U YES	s syllkino	Speci	No			Specify	White
	밀	15. DEC (Specify on		Give kind of	work done	CCUPATIO	ON ost of worki	ing	168	. KIND OF BUS	SINESS/INDU	STRY			
M m M	LET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	le. Do NOT a						-			
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, A	Airirile (ast)			leach	er	-	10 MOT	HED'S N		Elemen		Scho	01
Z 2 2 1	EC	Harry Elmen		11iams							and the same	obaugh	Surneme)		
MARY retained to 5 should notified	00	190. INFORMANT'S NAME (TTTGMO	1	96. MAJLIN	O ADDRESS	(Street				ber, City or Town	n, State, Zip (Code)	
2 - 0 5	유	Gary J. Lat	ıffer			1610	7 Aud	lubo	n La	ne	Bowi	e Mary	land	207	16
		20e. METHOD OF DISPOSIT	on 3 Ren	noval from State	20b. PLACI	E AND DATE	OF DISPOS	ITION /No	ame of		DAT	E 20c. LO	CATION — C	lty or Tow	n, State
BALTIMOR or death. Page 6 ma the funeral director. p. al. I examiner must		1										94 Ir	win P	enns	ylvania
BALTIM after death. Page y the funeral dire noval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Pobert E Evans Pres. 22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715													
2 2 2 3		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
68760 escuted within noun and completely filled in burial, cremation, or attic event, the me	NO	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
certificat ding phy tyglene p	CERTIFICATION	If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inj that initiated events resulting in death) LAS	ING ury	C	on a cons	EOUENCE (DF):	ros	4.Ś						
S, deat death		PART II Other signific	ant conditio	ne contribution to							0:41				
Signed by Health ar was any	4: MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the							iying ceuse given in Part I. 24a. WAS AN PERFOR 1 YES 2			MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ITAL V: The law cate has b State Dept.	SICIAN:	25. WAS CASE REFERRED 1	TO MEDICAL	HOSPITAL:					LACE OF E	DEATH (C	heck only or	10)			
OF VITAL RI HYSICIAN: The law rethinks certificate has been with the State Dept. of ked, or item 23 sh	YSI	1 TYES 2 NO		1 ScInpatient 2	☐ ER/Outpatient	3 🗆 DOA	4 Nur		ne 5 🗆 R	asidence	6 🗆 Othe	er (Specify)			
ON OF VITAL RE DING PHYSICIAN: The law requ After this certificate has been death with the State Dept, of s marked, or item 23 sho	ВУ РНУ	27, MANNER OF OEATH 1 Natural 5 2 Accident	Pending Investigation	28a. DATE Of (Month, I	FINJURY Day, Year)	28b. TH	ME OF JURY M	WC	JURY AT ORK? YES 2 [□ NO	28d. OE	SCRIBE HOW I	NJURY OCCI	JREO	
TISIC TITENDI CTOR: A after 6	8	3 Suicide 6 4 Homicide	Could not be determined	28a. PLACE (building	OF INJURY — At I , etc. (Specify)	nome, term,	street, fact	ory, offic	:•			ATION (Street of Town, Stete)	and Number o	r Rural Ro	oute Number,
HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours	COMPLET			BICIAN: To the best of											end manner ee stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If		29b. SIGNATURE AND TITL			H Her	1 design	PI	VC	29c, LIC	ENSE NU	MBER		29d. DATE	SIGNED (Month Day Year)
D THE SE FIND	TO BE	30. NAME AND ADDRESS O	G PERSON W	Bret HO COMPLETED CAL	Clin JSE OF DEATH (IT	EM 27) (Typ	o, Print)	,	D	16	063	3	> /:	2-1	-94 Bowle , MD 2015
(6)		David	A. 3	etche	· m	0	143	00	Ea.	llar	1+	Fox 1	'u.,	118	MD 20715
			1994	Julia Da	AR'S SIGNATURE	ndall									

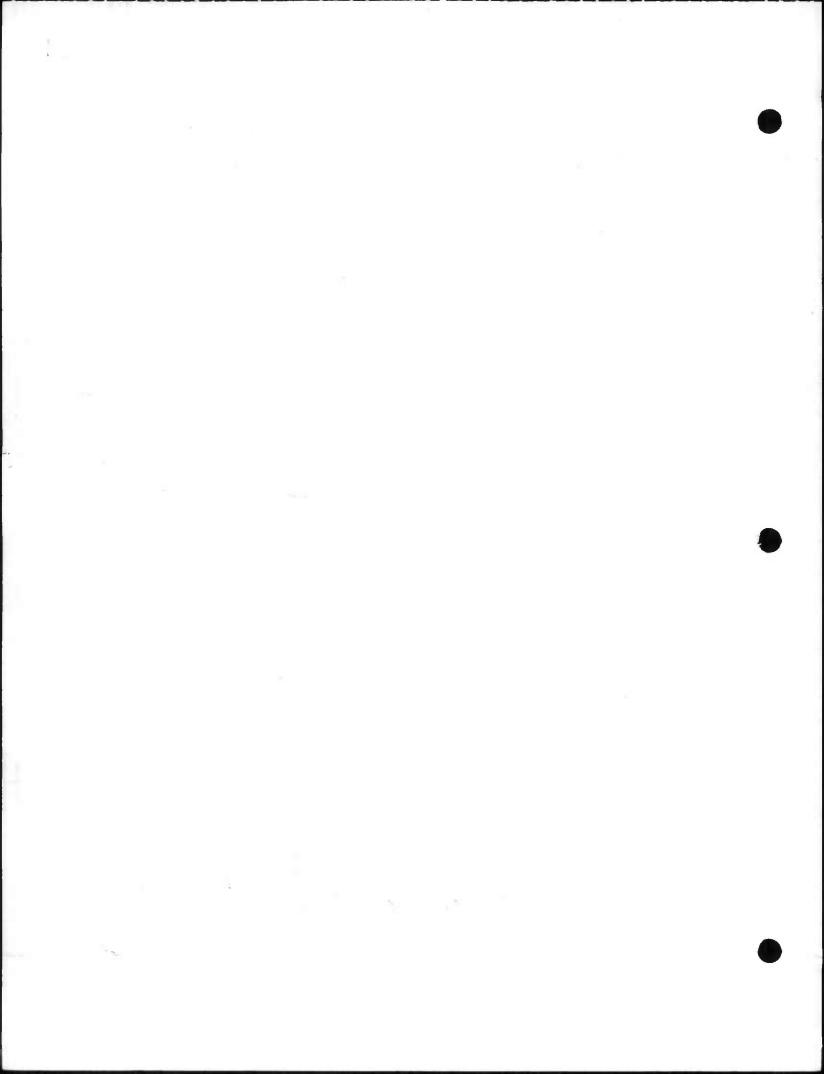
TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. Of Health and Merital Hygiene prior to burial, cremation, or removal associated to removal or them 28 is marked on them 23 should an unitary an other trainmatic event the medical examiner must be marked. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		CERTIF	ICATE U	F DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DE	EATH		
	Herbert Edward K	nickman dr				November 7	199	94 0457	- 4		
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State of	Camina		
1		1 M 2 🗆 F	79 YRS.	MONTHS DAY		(Month, Day, Year)		Country)			
	216-09-2729		79 ms.				1915	Maryland	d		
	9a. FACILITY NAME (If not institution, give st			9b. CITY, TOW	N OR LOCATION OF D	EATN	9c. COUNTY	OF DEATH			
0	Kent & Queen Anne	's Hospital	Inc.,	Cheste	ertown		Kent				
5	RESIDENCE OF DECEDENT										
DIRECTOR				Y, TOWN OR LO				10d. INSIDE C	ITY		
	-	een Anne's		Cheste	rtown		1 TES & W NO				
A	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	OF WHAT COUNTRY	7		
띪	203 Longfello	w Dr.			21620		U.	S.A.			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS (DECENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No. 14	. RACE — American Ir	dlan.		
IL.	1 Never Married 2 Adarried	FORCES? 1 YES	2 NO	II yea,	specify Cuban, Maxica	in, Puarto Rican, atc.)		Black, White, alc.	,		
₽	3 🗋 Widowed 4 🗋 Divorced	WW II	ALES	,,,	YES 2 X NO Specif	у:	į.	Spec#y: Whi	te		
	15. DECEDENT'S EDUC	CATION	18a. DECEDENT'S	USUAL OCCUP	ATION	16b, KIND OF BUS	SINESS/INDIAS				
COMPLETED	(Specify only highest grade		(Give kind of life. Do NOT u	work done during	most of working			y Glass	CO		
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	Glassw	orkor		Carr	HOWLC	y orass			
<u> </u>	17. FATHER'S NAME (First, Middle, Last)		GLASSV	Orver							
COM	The state of the s					ME (First, Middle, Malden	Surname)				
	Herbert J. Kn	ıckman				Fisher					
TO BI	190, INFORMANT'S NAME (Type/Print)	Tr 1 . 1				Route Number, City or Town			04.66		
	Elizabeth K.	Knickman	203	Long	tellow r	or., Ches	terto	wn, Md.	2164		
ž	20a. METNOD OF DISPOSITION 1 ☐ Burlel 2 St Cremation 3 ☐ Ramo		b.PLACEANDDATE		(Name of	OATE 20c. LO	CATION - City	or Town, State			
	4 Donation 5 Dother (Specify)	Ce.	metery, cremetory or o		Nov.	8,1994 B	altim	oro Md			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	THOULD	22. NAME	AND ADDRESS OF FA	CILITY	a 1 1 1 1 1 1	OLE, MU	•		
מעסווווופן וווחפין חפיי	1 101	V.000	()			ein Fune			.A.		
	Truk J. g	elferer	ein	130	Speer F	d., Ches	terto	wn, Md.			
	23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cause on each line.										
	interval Between Onset and Death Image: Carclial Season of Constant Consta										
	disease or condition	10.11	ncan	fig1	tu fr	ection	4	i 1 /			
1	reaulting in death)	DUE TO (OR AS	A CONSEQUENCE O	Pi:	440	Color	^	1 11	our		
5	_			,	4			i			
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS	A CONSEQUENCE O	B.							
A	if sny, lasding to immediate csuse. Enter UNDERLYING	(**********************************		,					l		
	CAUSE (Disease or injury	DUE TO (OR AS	A CONSEQUENCE O	D.				<u> </u>			
	that initiated events resulting in death) LAST			,,				į	- 1		
		1									
	PART II. Other algolificant conditions	s contributing to death	out not reaulting	In the underly	ring cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY	FINDINGS		
EDICAL	durinic of	churchy .	01		Disras	PERFOR	MEO?	AVAILABLE PRIC	OR TO		
		SIMOUTH	a car out	7-		1 TES 2	NO	OF DEATN?	CHUSE		
Σ	Hypertansion							1 🗌 YES 2 🗆	NO		
PHYSICIAN:	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C				N			1		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOERTAL	28. PLACE OF DEAT		ne)						
S	1 TES 2 NO	HOSPITAL:	petient 3 DOA	OTHER: 4 Nursing N	ome 5 🗆 Residence	8 Other (Specify)					
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c.	INJURY AT	28d. DESCRIBE NOW II	NJURY OCCUR	EO			
6	Netural 5 Pending	(Month, Day, Year)	INJ		WORK?				- 1		
B	2 Published	28e. PLACE OF INJUR	/ — At home, lerm, :	treel, factory, o	Mica	281. LOCATION (Street a	and Number or I	Rural Bouta Number			
	4 Nomicide 8 Could not be	building, etc. (Spe	cify)			City or Town, State)	ING NUMBER OF I	nurer noute rromber,	- 1		
ш	29e. CERTIFIER					L					
릴	(Check only CERTIFYING PHYSIC	CIAN: To the best of my know									
COMPLETED	one) 2 MEDICAL EXAMINER	R: On the basis of axemination	n and/or investigation	n, in my opinior	, death occured at the	time, date end placa, and	d due to the co	suse(s) and manner as	stated,		
	29L SIGNATURE AND PITTE OF CENTIFIER	1			29c. LICENSE NUI	MBER . I	29d. DATE SI	GNED (Month, Day, Yes)c)		
8	G Du	unceu			I DAN	354	> 17	8194	"		
일	20. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATN (ITEM 27) /Free	Print)	1 000		- // /	777			
	Cottleied Ro.	mann n) D -/	host	DE ININA	mal	21/2	20	- 1		
	31. DATE FILED_Magth, Day, Year)	J. K. C. L. L.	I'V (HEST	CI TUWII	1/101	410a	40			
	NOV 9 1994	32. BIGISTRAR'S SIGN	ATURE								
	TOUT 0 1007	1 man wand	man of a								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be cleared about that the Character of the control of the

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		ENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, I					2. DATE OF DEATH MONTH	1	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 214-09-2445	5. SEX 6. AGE ((In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 23, 19		BIRTHPLACE (State or Foreign Country) ryland			
СТОВ	90. FACILITY NAME (If not institution, Washington Cour	nty Hospital			R LOCATION OF OEA		9c. COUNTY	of DEATH ington			
DIREC	RESIDENCE OF DECEDEN 10a. STATE 10b. CO Maryland Was			town or Locate	170			10d. INSIDE CITY LIMITS? t YES 2 NO			
FUNERAL	104. STREET AND NUMBER Avalon Manor Nu	rsing Home			ZIP CODE 21740			OF WHAT COUNTRY?			
B	11. MARITAL STATUS 1. Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN FORCES? 1 YE YES IF YES, GIVE WAR OR D. W.W.II	2 NO ATES		cify Cuban, Mexican,	C ORIGIN? (Specify Yes Puerto Ricen, etc.)		RACE — American Indian, Black, Whita, atc. Specify: White			
PLETED	15. OECEDENT'S (Specify only highest Elementary/Secondary (0-12)	EDUCATION grade completed) College (1-4 or 5 +)	ille. Do NOT use	ork done during mos	N It of working	166. KIND OF BUS		RY			
at once.	17. FATHER'S NAME (First, Middle, Las Karl T. Kubert			MOLGET		E (First, Middle, Maiden	Surname)				
TO BE	19a. INFORMANT'S NAME (Type/Print) Carl Kubert				nd Number or Rural Ro	ute Number, City or Town	n, State, Zip Code				
must be	20a. METHOD OF DISPOSITION 11 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State 20b	PLACE AND DATE OF DETERMINED IN COMMENTS OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	F DISPOSITION (Ner	me of	DATE 20c. LO	CATION — City				
medical examiner must	21. SIGNATURE OF FUNERAL SERVICE	TIMMenne	ich		H FUNERAL Wilson	HOME		n, Md. 21740			
ent, the medica	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Dispro (OR AS A CONSEQUENCE OF):										
aumatic ev	Sequentially list conditions, If any, leading to immediate Incumix Incu										
injury, or other traumatic event, the	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.										
shows any Injure: MEDICAL (PART II. Other significant cond	etine He	disea.	the underlying	ceuse given in P	art I. 24a. WAS AN PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
SICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?	NTRIBUTE TO CAUSE O	28. PLACE OF DEATH	(Check only one)	UNCERTAIN						
ked, o	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigat	28a. DATE OF INJURY (Month, Day, Year)		OF 28c. INJURY WOF		Other (Specify) 28d. DE\$CRIBE HOW IN	JURY OCCURE	D			
28 Is TED	2 Accident Investigat 3 Suicide 8 Could no 4 Homicide detarmine	26s. PLACE OF INJURY building, atc. (Spec	— At home, farm, atr	reet, factory, office	3	281. LOCATION (Street a City or Town, State)	nd Number or Ru	ural Route Number,			
음의		HYSICIAN: To the best of my know						use(s) and manner as stated.			
IMPORTANT: II	296. SIGNATURE AND TITLE OF CENT	r_			29c, LICENSE NUMB	er 6	29d. DATE SIG	NED (Month, Day, Year)			
F	30. NAME AND ADDRESS OF PERSON	1 Alikan 2	0311 6	affans	ed 13	Rondno	Mb	2/7/3			
	31. DATE FILED (Month, Day, Year) DEC 0 2 1994	Juli Senden		/							

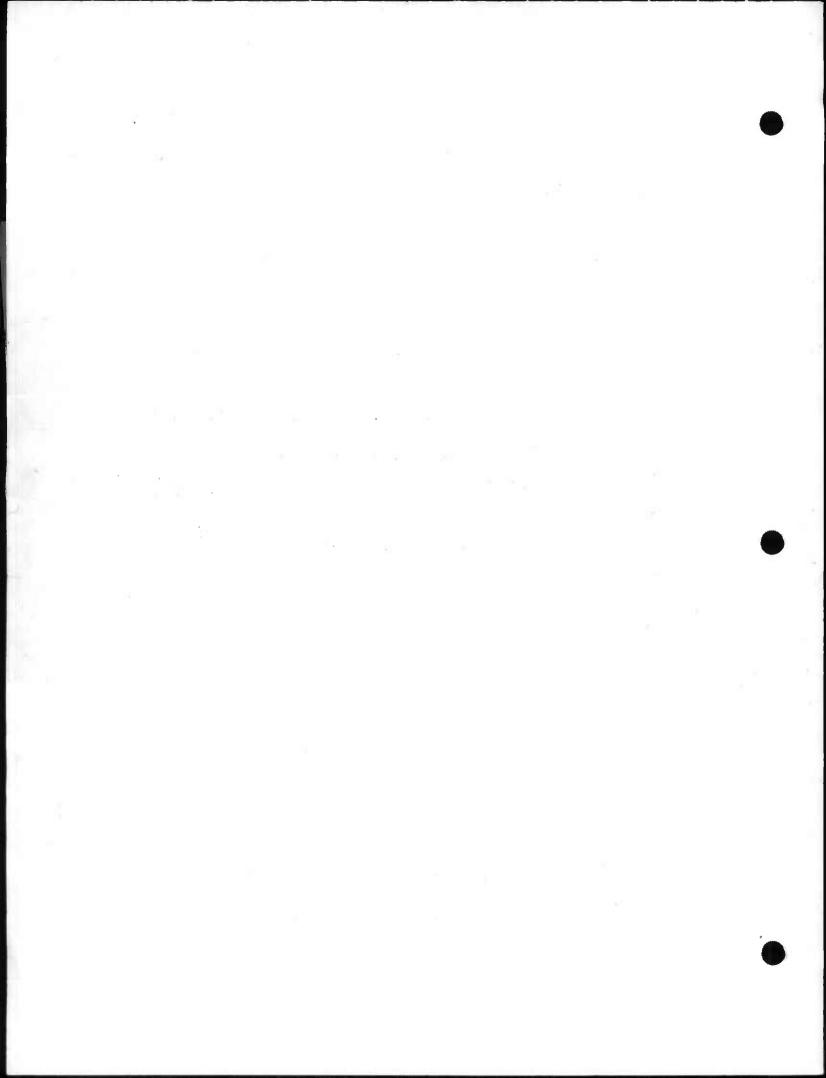
A .

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

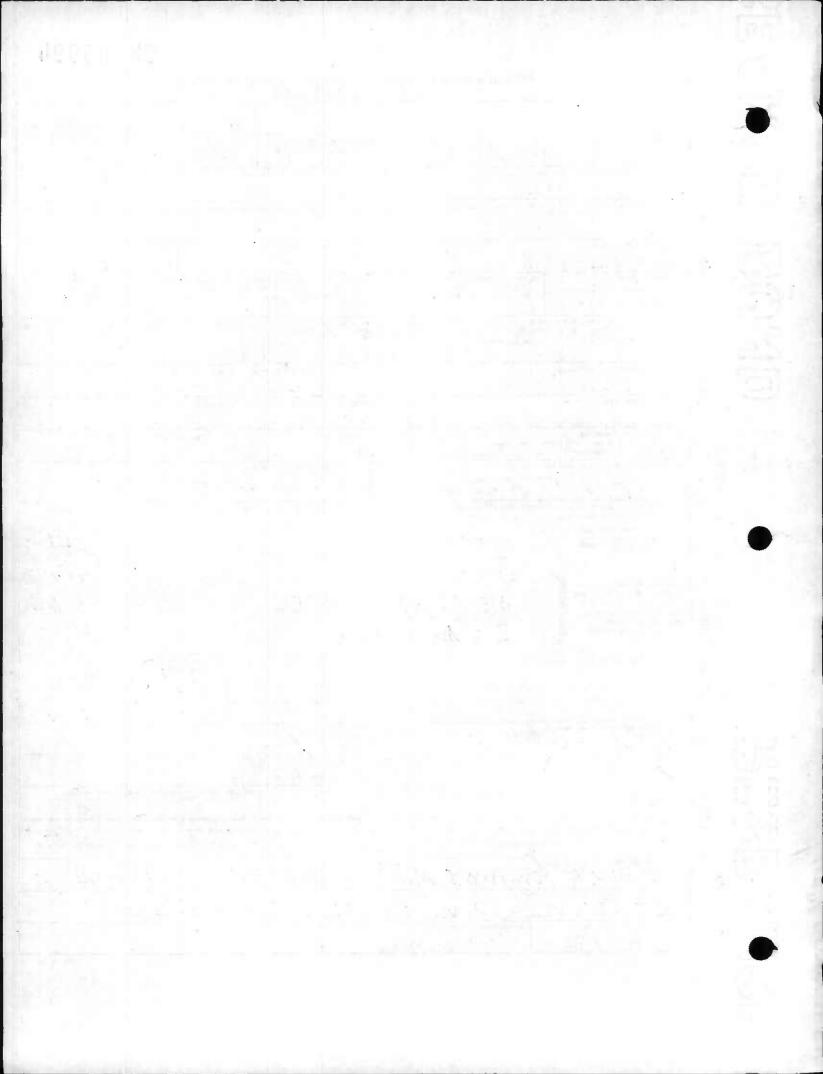
TENDING PHYSICIAN: The law requires that the death certificate be executed within exhours after death. Page 6 may be retained by the hospital or attending physician.		after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT. It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN	TO THE FUNERAL OIRECTOR: After this certific	be filed within 72 hours after death with the S	IMPORTANT: It item 28 is marked, or i

								94	36993	
	1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND /	DEPAR	TMENT OF	HEALTH AND	MENTAL HYGIEN REG. NO			
- 8	1. OECEOENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH D	av v	3. TIME OF DEATH	
1	Henry Paul Kotur	l					December		7:30 A. M	
	4. SOCIAL SECURITY NUMBER 180-26-4789	5. SEX 6. A	AGE (In yrs. last	birthday) YRS.	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year) JULY 31,	1931 F	BIRTNPLACE (State or Foreign Country) ENNS YLVANIA	
E I	9a. FACILITY NAME (H not institution, give street end number) 428 N. Potomac St.					n or Location of Di lagerstown	EATH	9c. COUNTY OF DEATH Washington		
RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY 10c. CITY, TOWN OR LOCATION								l		
DIRECTOR	Md. 106. COUNT	10c. CIT	Hage	rstown			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
BY FUNERAL	100. STREET AND NUMBER 428 N. Potomac S	t.	_			10f. ZIP CODE 1740)		J.S.A	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yas or No.) 14. RACE — Armed							RACE — American Indian, Black, White, etc.			
10.00.00								Specify: te		
	15. OECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DEC (G/s	CEOENT'S	USUAL OCCUPA work done during se retired.)	TION most of working	16b. KIND OF BU	SINESS/INDUS	TRY	
COMPLETED	Elamentary/Secondary (0-12)	College (1-4 or 5+)	lite.		cher		<u>`</u>	gh Scho	ool	
BE CO	17. FATNER'S NAME (First, Middle, Last) Michael Kotun					Mary	ME (First, Middle, Meiden Chory			
101	190. INFORMANT'S NAME (Type/Print) GENNY S. KOTUN		42	8 N.	ADDRESS (Street) Potom	et end Number or Rural ac St. Ha	Route Number, City or Forgers town, M	d. 217	40	
	20a. METNOD OF DISPOSITION 1	noval base State	20b. PLACE A cemetery, crer	ND DATE	OF DISPOSITION ther place! カゥー(カッド	Neme of	DATE 20c. LC	nithsbu	or Town, Stata	
	21. S CHATURE OF FUNERAL SERVICE	CENSEE	Silvec	10300	22. NAME	AND ADDRESS OF FA	CILITY 1959		oury Ave.	
Ш	Mennish.	Torre	2			s Funeral	Home Smith	isburg,	Md. 21783	
	23. PART I. Enter the diseases, or shock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acquire	on each lina.						Interval Between	
z	Sequentially list conditions,	DUE TO (OR	AS A CONSEC	UENCE O	F):			•		
CATIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR	AS A CONSEC	UENCE O	F):					
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEC	UENCE O	F):					
1 - 1	PART II. Other significant condition	ns contributing to dea	th but not re	neultles.	In the underly	dag seves glves le	Seed I Dec 1980 to	LAITTONAV	24b. WERE AUTOPSY FINDINGS	
MEDICAL				additing	in the underly	mig causa given in	Part i. 24a. WAS AN PERFOI	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
							_		1 TES 2 NO	
A	25. WAS CASE REFERRED TO MEDICAL				26	PLACE OF DEATH (CA	eck only one)		l	
Sic	1 Tyes 2 NO	HOSPITAL:	Outpatient 3	□ DOA	OTHER:	lome 5 Raaldenca	6 Other (Specify)			
Y PHYSICIAN:	27. MANNER OF DEATN 1 Netural 5 Pending Investigation	28a. DATE OF INJU (Month, Day, Ye		28b. TIN	E OF 28c.	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUR	IED	
ED BY	2 Accident investigation 3 Suicide a Could not be 4 Nomicide detarmined	28s. PLACE OF IN. building, atc.	JURY — At hor (Specify)	ma, farm,	straet, factory, o	ffice	28f. LOCATION (Street City or Town, State		Rural Route Number,	
COMPLET		SICIAN: To the beat of my I								
CO	2 MEDICAL EXAMIN		nation and/or i	nveatigetic	on, in my opinio				ause(a) and manner as stated.	
TO BE	4 Today	clescon	M	0		DH9	MBER 15	▶ 12	IGNED (Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CAUSE O	F DEATH (ITEM	27) (Type	Print) C	ampus	Rd Has	rersti	aon Md.	
	31. DATE FILED (Month, Day, 16ar) DEC 05 1994	32. REGISTRAR'S	SIGNATURE					J	\ .	
			,						OHMH-16 Rev 1/89	



BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Last)	OLITIFI	CATE OF	PERIT	2. DATE OF	REG. NO.		3. TIME OF DEATN
MICHELLE	Helen	KALMANOW	ICZ		MONTH	DAY	94	0915 A
4. SOCIAL SECURITY NUMBER	/	AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTN by Yhari		NPLACE (State or Foreign
172-40-3018	1 DM 2 DF	46 YRS.			July .	24, 1948		NPLACE (State or Foreign Pa.
9a. FACILITY NAME (If not institution, g	to be a second of the second			OR LOCATION OF D	EATH		NTY OF E	
14640 W. Cherry			Ridge	БТА		Ua Ua	roli	tne
10a. STATE 10b. CO			, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
Md. Car	roline		Ridgely	t, ZIP CODE		Towns or		1 TES 2 NO
14640 W. Cherry	7 In			21660			J.S.A	WHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT ET	VER IN U.S. ARMED	13. WAS DEC	ENDENT OF NISPA		pecify Yes or No-		E — American Indian,
1 Never Married 2XX Married 3 Wildowed 4 Divorced	FORCES? 1 [] IF YES, GIVE WAR			ecify Cuben, Mexico		n, etc.)	Spec	ck, White, etc.
16. DECEDENT'S	EDUCATION	14. DECEDENTIO	HOULAN GOOD BATTO		1 200 000			
(Specify only highest s	grade completed)	16e. DECEDENT'S (Give kind of w life. Do NOT us	vork done during mo	ost of working	16b. Kil	ID OF BUSINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Teach	er		Pub	lic Schoo	1	
17. FATHER'S NAME (First, Middle, Last	ii)					le, Meiden Surname)		
Paul S. Suda					a Jenz			
190, INFORMANT'S NAME (Type/Print)						City or Town, State, Zip		
Thad Kalmanowic	2Z	1404U			Kidgel	y Md. 216	-	
1 Buriel 2 Cremation 3 4 Donation 5 Other (Specify)		cometery, crematory or of Holy Cross	her place)		-5-94	Dentor		
21. SIGNATURE OF FUNERAL SERVICE		11029 02000		ND ADDRESS OF FA				
1/ 19	The	>	P.O.	Box 160	Greens	boro Md.	2163	39
23. PART I. Enter the diseases,	, or complications that cr	sused the death. Do n	ot enter the mo	ode of dying, aud	ch as cardiac	or reapiratory an	reat.	Approximate
ahock, or heert fello	lure. Liet only one ceuse	on each line.					,	Interval Betwee
disease Dr condition resulting in death)	. INFE	CTION						174hp
roadming in doubly	DUE TO (OF	AS A CONSEQUENCE OF	፣):				1,00	101
		NEF						115hn
Sequentially list conditions,	1 07/RC	21760						70/110
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR MET	AS A CONSEQUENCE OF		KEP				4Uns
If any, leading to immediate	. MET	AS A CONSEQUENCE OF ASTATION	CAN	ICER				44rs
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	. MET	ASTATIC	CAN	ICER				4yrs
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. <u>ME7</u> DUE TO (OR d. <u>BR</u>	ASTATICA AS A CONSEQUENCE OF BAST (A)	NCER		Part I. 24	S. WAS AN AUTOPSY	24	4yrs,
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c. <u>ME7</u> DUE TO (OR d. <u>BR</u>	ASTATICA AS A CONSEQUENCE OF BAST (A)	NCER			PERFORMED?	241	AVAILABLE PRIOR TO COMPLETION OF CAUSE
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. <u>ME7</u> DUE TO (OR d. <u>BR</u>	ASTATICA AS A CONSEQUENCE OF BAST (A)	NCER				241	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. <u>ME7</u> DUE TO (OR d. <u>BR</u>	ASTATION AS A CONSEQUENCE OF	NCER			PERFORMED?	241	AVAILABLE PRIOR TO COMPLETION OF CAUSE
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDIC EXAMINER?	c. MET DUE TO (OF BR)	ASTATION AS A CONSEQUENCE OF	THE UNDERLYIN		_	PERFORMED?	241	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINERY 1 YES 2 NO	c. ME7 DUE TO (OR d. BR ditione contributing to de	ASTATION AS A CONSEQUENCE OF STATE OF S	26. P	g couse given in	heck only one) 6 Other (S	PERFORMED? YES 2 NO		OF DEATH?
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	d. DUE TO (OR BR) d. BR diltione contributing to de	ASTATION AS A CONSCOUENCE OF SASTA CAPACITY AS A CONSCOURT AS A CO	26. PI OTHER: 4 Nursing Non E OF 26c. IN. WX	g couse given in	heck only one) 6 Other (S	PERFORMED? YES 2 NO		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	C. DUE TO (OR d. DUE	ASTATULE R AS A CONSEQUENCE OF AS A CONSEQUENCE OF R/Outpetlent 3 DOA R/OUTPETLENT B/ R	26. PI OTHER: 4 Nursing Non E OF URY M 1	g couse given in	6 Other (S	PERFORMED? YES 2 NO Decity) BE NOW INJURY OC ON (Street and Number	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	C. DUE TO (OR d. DIE	ASTATULE R AS A CONSEQUENCE OF AS A CONSEQUENCE OF R/Outpetlent 3 DOA R/OUTPETLENT B/ R	26. PI OTHER: 4 Nursing Non E OF URY M 1	g couse given in	6 Other (S	PERFORMED? YES 2 NO DOCITY) BE NOW INJURY OC	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICE EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending Investigat 2 Accident 3 Suicide 6 Could no determine	C. DUE TO (OR d. DUE	R/Outpetient 3 DOA R/Outpetient 3 DOA JURY 2eb. TIM INJ NJURY — At home, farm, a	26. Pl OTHER: 4 Nursing Non E OF 26c. IM. WK M 1	g couse given in	6 Other (S 28d, DESCRI 26f, LOCATIC City or X	PERFORMED? YES 2 NO Decity) BE NOW INJURY OC ON (Street and Number own, State)	CURED v or Rural	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending Investigat 3 Suicide 6 Could no determine. 29e. CERTIFIER (Check only) CERTIFYING F	C. DUE TO (OR d. DIE	R/Outpetient 3 DOA R/Outpetient 3 DOA JURY 2eb. TIM INJ NJURY — At home, farm, a knowledge, death occurre	26. POTHER: 4 Nursing Non E OF 26c. IN. WY M 1 United the time, date	g couse given in	heck only one) 6 Other (S) 28d, DESCRI 26f, LOCATIC City or Ti	PERFORMED? VES 2 NO Decity) BE NOW INJURY OC ON (Street and Number own, State)	CURED or Rural	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending Investigat 3 Suicide 6 Could no determine. 29e. CERTIFIER (Check only) CERTIFYING F	C. DUE TO (OR DUE	R/Outpetient 3 DOA R/Outpetient 3 DOA JURY 2eb. TIM INJ NJURY — At home, farm, a knowledge, death occurre	26. POTHER: 4 Nursing Non E OF 26c. IN. WY M 1 United the time, date	g couse given in	6 Other (S) 28d, DESCRI 26f. LOCATIC City or T	PERFORMED? YES 2 NO Decily) BE NOW INJURY OC ON (Street and Number own, State) and manner se state place, and due to ti	counced or or Rural ted.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident Investigat 3 Suicide 6 Could no determine (Check only one) 2 MEDICAL EXA	DUE TO (OR d	ASTATULE RAS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF BAS A CONSEQUE	26. Pi OTHER: 4 Nursing Non E OF 26c. IN. URY M 1 street, fectory, office and at the time, date on, in my opinion, of	g couse given in	6 Other (S) 28d, DESCRI 26f. LOCATIC City or T	PERFORMED? YES 2 NO Decily) BE NOW INJURY OC ON (Street and Number own, State) and manner se state place, and due to ti	counced or or Rural ted.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (e) and manner se stated.
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident 3 Suicide 6 Could no determine 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIDITY (CHECK ONLY ONE)	DUE TO (OR d	R/Outpatient 3 DOA JURY 28b. TIM NJURY — At home, farm, s knowledge, death occurre instion end/or investigation OF DEATH (ITEM 27) (Type,	26. P. OTHER: 4 Nursing Non EOF 26c. IN. WY 1 street, fectory, office od at the time, date n, in my opinion, o	g ceuse given in LACE OF DEATH (Ci ne 5 Residence JURY AT YES 2 NO ne ne end place, end du death occured at the	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	PERFORMED? YES 2 NO Decily) BE NOW INJURY OC ON (Street and Number own, State) and manner se state place, and due to ti	counced or or Rural ted.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (e) and manner se stated.
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident Investigat 3 Suicide 6 Could no determine (Check only one) 2 MEDICAL EXA	DUE TO (OR d	RASTATION R AS A CONSEQUENCE OF ROUTE AND THE STATE OF DEATH (ITEM 27) (Type, UNE CONSEQUENCE OF RAS A CONSEQUENC	26. P. OTHER: 4 Nursing Non EOF 26c. IN. WY 1 street, fectory, office od at the time, date n, in my opinion, o	g couse given in	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	PERFORMED? YES 2 NO Decily) BE NOW INJURY OC ON (Street and Number own, State) and manner se state place, and due to ti	counced or or Rural ted.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (e) and manner se stated.



3. TIME OF DEATH

1242

8. BIRTHPLACE (State or Foreign

Wash DC

10d. INSIDE CITY

White

Approximata

24b. WERE AUTOPSY FINDINGS

1 TYES 2 NO

29154

29d. DATE SIGNED (Month, Day, Year)

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

interval Between

Onset and Death

2-344

1 TES 2 NO

9c. COUNTY OF DEATH

Calvert

10g. CITIZEN OF WHAT COUNTRY?

Specify:

U.S.A.

14. RACE — American Indian, Black, White, etc.

REG NO

2. DATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

FOR STATE

REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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31. OATE FILEO (Month, Day, Year)

DEC

Mary November 29, 1994 Natala Lubbes 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Dec 13, MONTHS DAYS HOURS 578-42-1535 1 🗌 M 2 🔀 F 65 YRS 1928 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Calvert Memorial Hospital Prince Frederick RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Calvert. North Beach 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burfal-transit 9230 Annapolis Avenue 20714 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 Married BY 1 TES 2 NO Specify: 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INQUISTRY (Specify only highest gi Elementary/Secondary (0-12) College (1-4 or 5+) 12 COMPL Cashier Retail Grocery 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary 76 Sam Celia Alice Hafner BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sandra Lowery 9222 Annapolis Avenue North Beach, MD 20714 e 20a. METHOD OF DISPOSITION
1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Southern Mem. Grdns 4 Donation 5 Other (Specify) 12-2-94 Dunkirk, MD medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Willean Rausch Funeral Home, PA Owings, filled in by the 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. within 24 nours 0 IMMEDIATE CAUSE (Fine) Renal traumatic event, the cremation, Failene disease or condition resulting in deeth) and completely fi burial, cremation hrence DUE TO (OR AS A CONSEQUENCE OF) executed and (CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING physician prior death certificate CAUSE (Disease or Injury other / the attending phy d Mental Hygiene r OUE TO (OR AS A CONSEQUENCE OF): that initiated events raculting in death) LAST 6 injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuee given in Part i. MEDICAL 24s. WAS AN AUTOPSY signed by the PERFORMED? Cerebon vascerla shows any 1 TES 2 NO Dyperleni. has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, item certificate h HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Raaldence 6 □ Other (Specify) 1 TES 2 DO 1 Department 2 ER/Outpatient 3 DOA 5 27. MANNED OF DEATH 28a. OATE OF INJURY (Month, Day, Year) this c 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED is marked, Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 28 Hem OR 29a. CERTIFIER ***CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and menner as stated. THE HOSPITAL (
THE FUNERAL D = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Allonde Tomuna. MD 19427

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print

1 1994

32 REGISTRAR'S, SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

OHMH-16 Rev 1/89

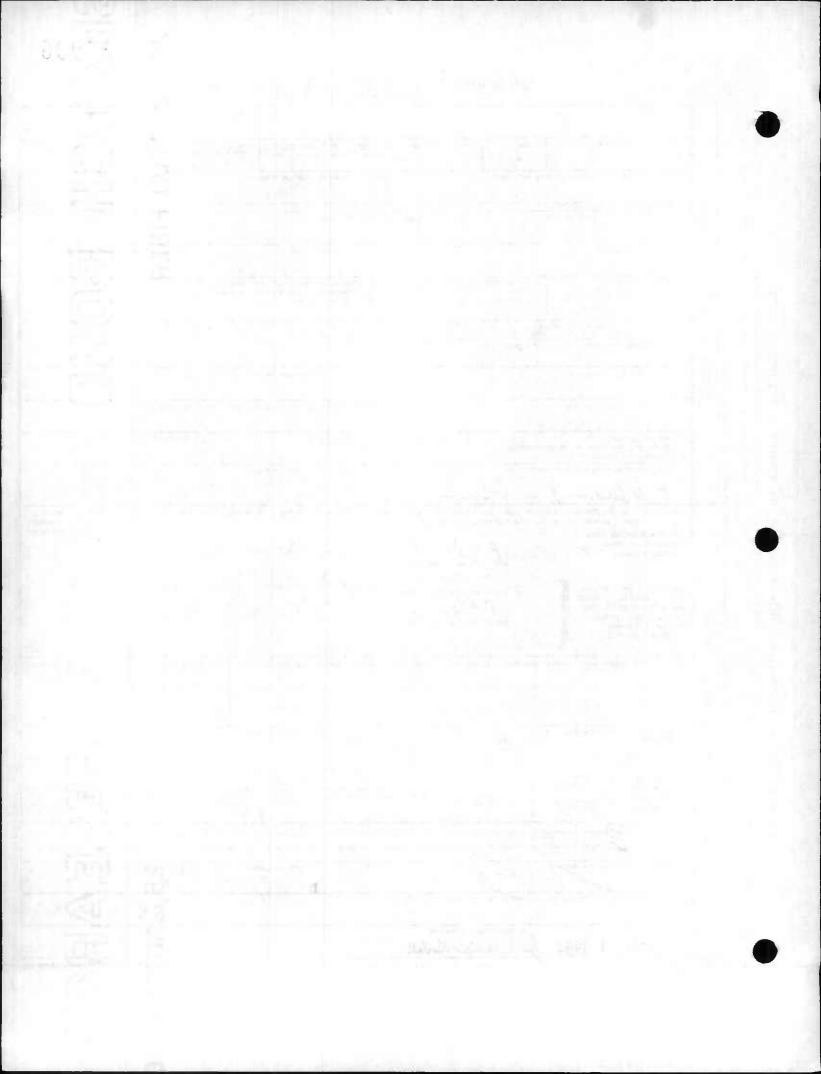
BALTIMORE, MARYLAND 21215-0020	Jurs after death. Page 6 may be retained by the hospital or attending physicia	filled in by the funeral director, page 5 should be detached for use as the burial-to
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jurs after death. Page 6 may be retained by the hospital or attending physicia	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to-

lending physician. as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the four after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If I liem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH	AND MENTA	L HYGIENE
	ERTIFICATE	OF DEAT	H	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIEN	-		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Blanche Aurore	Leroux				NOV. 29	1994	6:38 a M	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (II	- "	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign	
	077-03-3715	1 M 2 X F	93 YRS.	OCITY TOWN	PR LOCATION OF D	Sep 30,	1901 Coun	NH	
TOR	Calvert Memoria		ederick Calvert						
DIRECTOR	10e. STATE 10b. COUNTY	Calvert	OWN OR LOCAT	Owin	ne .	10d. INSIDE CITY LIMITS? 1 YES 2 V NO			
	10e, STREET AND NUMBER	Carvere		101	. ZIP CODE	95	1 ☐ YES 2 🛣 NO		
FUNERAL	9120 Easy Str		2	0736	USA				
BY FUI	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2 NO TES	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexica 2 X NO Specti	NIC ORIGIN? (Specify Year, Puerto Rican, atc.) y:	Yee or No- 14. RACE — American Indian, Black, White, stc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION	16a. DECEDENT'S US	UAL OCCUPATION	ON	166. KIND OF BU	SINESS/INDUSTRY		
Li I		College (1-4 or 5+)	(Give kind of work life. Do NOT use re	t done during mo itirad.)	ist of working			100	
MP	8		seamst	cess		garı	ment	6.53	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Meider			
BE	Albert Gailla	ırdetz			Mar.				
0	19a. INFORMANT'S NAME (Type/Print)				_	Route Number, City or Tox	vn, Stete, Zip Code)		
	Claire M. Casey				0 above				
	20e. METHOD OF DISPOSITION 1	al from State 20b.	PLACE AND DATE OF E efery, cremelogy or other Linco	place) In Ce	metery	Dec. 2, 1	994 Bren	twood, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME AL	ND ADDRESS OF FA	CILITY			
	* William &	from				Home, P.A. armony L	n.,Owin	gs, MD	
	23. PART I. Enter the diseases, or cor shock, or heart failure. Lie	mplicetions that caused	the desth. Do not	enter the mo	da of dying, aud	h as cardiac or reap	Iratory arrest,	Approximata Interval Between	
	IMMEDIATE CAUSE (Finel	it only one cause on co						Onset and Death	
	disease or condition resulting in desth) a.	Acut	+ Pula	ona	, Ede-	2			
		DUE TO (OR AS A	CONSEQUENCE OF):			1,			
Z	Sequentially list conditions, b.	4-566	ema	Care	lionope	,15			
AT	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):		1 1	- 1			
	CAUSE (Disease or Injury C.	DUE TO (OR AS A	CONSEQUENCE OF):	2 (40000	iscal 1) sel		
CERTIFICATION	that initiated events resulting in deeth) LAST								
S	d								
¥	PART II. Other aignificent conditions	contributing to death bu	ut not reaulting in t	ha underlyin	g ceuse given in		RMED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDIC						1 🗆 YES	2 🗆 NO	OF DEATH?	
뿔							101146	1 YES 2 NO	
ä									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	0	28, PI	ACE OF DEATH (C)	eck only one)			
XS		M Inpetient 2 ER/Outpe	atlent 3 DOA 4	Nursing Hor		6 Other (Specify)			
	27. MANNER OF DEATH 1 🔀 Natural 5 🗌 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	y wc	PRK?	28d. DESCRIBE HOW	INJURY OCCURED	64	
B	2 Accident Investigation	28e. PLACE OF INJURY	- At home form etco		YES 2 NO	281. LOCATION (Street	and Aliceber on Chief	Date Number	
TED	3 Suicide a Could not be 4 Homicide determined		City or Town, State		Plotte Number,				
COMPLET	29a. CERTIFIER Check only	AN: To the best of my knowle	edge, death occurred a	it the time, date	and place, and due	to the cause(s) and me	nner as atated.	1040.	
8	one) 2 MEDICAL EXAMINER:	On the beals of examination	and/or investigation, i	n my opinion, d	leath occured at the	time, data and place, a	nd due to the cause	(e) end menner ee stated.	
	290. SIGNATURE AND TITLE OF CERTIFIER	1/1			29c, LICENSE NU	мвен	29d, DATE SIGNE	D (Month, Dep. Mver)	
) BE	10	9/			A 33123		▶ 11-29	-94	
유	30. NAME AND ADDRESS OF PERSON WHO					DEPOS SI			
	Jonathan Lowent	hal, MD	Calvert	Medic	al Art	s Bldg, Pr	rince Fre	derick, MD	
	31, DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGNA							
	DEC 1 1994	Jahn Davidson	Randall						



NLTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Annual fleeting and precision or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

3	1. DECEDENT'S NAME (First, Middle, Last)		1	`		_			2. DATE	E OF DEATH	DAY	YEAR	3. TIME OF DEATH
	Norman	М	(Math	ner) L	ittell	Sr.			De	c 5	DAY 199	94	9:30P M
	4. SOCIAL SECURITY NUMBER	5. SEX		. AGE (In yrs. Ia	st birthday)	IF UNDER 1 Y	EAR IF U	NOER 24 HRS.		OF BIRTH	امدا		HPLACE (State or Foreign
	578-54-8180	1 💢		95	YRS.	months b	A7S HOU	MIN.	2.5	megant	Ind.		t 8 1899
~	9a. FACILITY NAME (If not institution, give					9b. CITY, TO	WN OR LO	CATION OF D	EATH		9c. COL	INTY OF D	
DIRECTOR	Pleasant Living (Conva	lescer	nt Cent	ter	Ed	gewa	ter			An	ne A	Arundel
H	10a. STATE 10b. COUNT				10c. CIT	Y, TOWN OR I	OCATION						10d. INSIDE CITY
		Arui	ndel_			Edg	ewate	er					1 TES 2 XNO
FUNERAL	10e. STREET AND NUMBER						101. ZIP C						WHAT COUNTRY?
N	144 Washington 11. MARITAL STATUS		250505					1037				Y	States
	1 Never Merried 2 Married	FORC	ES? 1	EVER IN U.S. AI	MO RWED	It ye	s, specify C	uban, Mexic	an, Puarlo	N? (Specify Y Rican, atc.)	ea or No-	14. RACI Blaci	E — American Indian, k, Whita, atc.
BY	3 X Idowed 4 Divorced	IF YE	S, GIVE WAF	OH DATES		1 1	YES 2	(O Speci	ffy:			Spec	White
	15. DECEDENT'S EDU (Specify only highest grade			16a. DE	ECEDENT'S	USUAL OCCU	PATION	nakina	160	b. KIND OF B	USINESS/IN	DUSTRY	
	Elamentary/Secondary (0-12)		(1-4 or 5 +)	lite	e. Do NOT us	e retired.)	ig most or w	Orking					
COMPLETED		8			Lav	vyer					Law	1	
	17. FATHER'S NAME (First, Middle, Last)						18. N			Middle, Maide			
H	Joseph Littell 19a. INFORMANT'S NAME (Type/Print)									Munge			
2	Oliver Hill					ADDRESS (S							20722
						OF DISPOSITION		Static		_	OCATION -		ro, MD
	20a. METHOD OF DISPOSITION 1 X Perial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	novet from	State			Ceme		12/8	1			•	aryland
	21. SILMATURE OF EUNERAL SERVICE L	PENSEE		1000	annoo	22. NAI	RE AND ADD	DRESS OF FA	ACILITY	ohn M	Tav	dor F	uneral Home
	DE Tomo V	1 <	\supset			147	Duke	e of (Gloud	ester	St. A	nnap	olis, MD
	23. PART I. Enter the diseases, or	complicat	Tons that o	aused the de	eeth. Do r								Approximate
	ahock, or heart fallure. iMMEDIATE CAUSE (Final	List only	Dne cause	on eech line	е.			,,			priority of	1000,	Interval Between Onset and Death
	disease or condition resulting in deeth)	- (AME	ESTIV		HFIL	IT I	ENII	110 1	_			Onset and Death
	reguiting in deeth)	0. [- 1			See.	1767		611 1	U/C				
			DUE TO (O	R AS A CONSE	OUENCE OF	ŋ;	7						
N	W. Sc.	b	DUE TO (O	R AS A CONSE	OUENCE OF	7):	7						
ATION	Sequentially liet conditions, if any, leading to immediate	b	DUE TO (O	R AS A CONSE	OUENCE OF	ን :							
-ICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b	DUE TO (O	R AS A CONSE	OUENCE OF	¬):							
RTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	b	DUE TO (O	R AS A CONSE	OUENCE OF	¬):							
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b	DUE TO (O	R AS A CONSE	OUENCE OF	-): -): -):							
AL CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. d.	DUE TO (O	R AS A CONSE	OUENCE OF	r): r): in the unde	lying ceus			24a. WAS A	N AUTOPSY	24b	WERE AUTOPSY FINDINGS
DICAL CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST PART II. Other significant condition ASPIRATION	c. d.	DUE TO (O	R AS A CONSE	OUENCE OF	r): r): in the unde	lying ceus			24a. WAS A	PRMED?	24b	
MEDICAL CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition ASPIRATION ACCIDENT	d.	DUE TO (O	R AS A CONSE	OUENCE OF	T): T): In the under	lying ceus	se given in	Pert I.	24a. WAS A	PRMED?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE
_	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST PART II. Other significant condition ASPIRATION ACCIDENT DID TOBACCO USE CONT	d.	DUE TO (O	R AS A CONSE	OUENCE OF	in the under	lying ceus	se given in	Pert I.	24a. WAS A	PRMED?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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BY PHYSICIAN:	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST PART II. Other significant condition ASPIRATION ACCIDENT. DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 29 Accident Suicide Could not be detarmined 29a. CERTIFIER (Check only)	c. d. TRIBUTE HOSP! 1 inpet	DUE TO (O DUE TO (O DUE TO (O DUE TO (O TAL: Hart 2 E DATE OF IN (Month, Day, PLACE OF I building, atc	R AS A CONSE R	OUENCE OF COUNTY OF THE COUNTY	in the under IS NC IN (Check only OTHER: 4 Nursing E OF 1 URY M 1	Ul one) Home 5 :: INJURY AWORK? YES deta and pi	NCERTAI Residence T 2 \(\sum \text{NO} \)	Pert I. 6 Other 28d. DE 26t. LOC City	24a. WAS A PERFC 1 YES PERFC 1 YES PERFC 1 Specify) SCRIBE HOW CATION (Street or Town, Stah	INJURY OC	course or Rural F	AWAR.ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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DIVISION OF VITAL RECORDS, P.

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 5-0020 IMPORTANT: If IIom 28 is marked, or IIom 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR	STATE OF N	MARYLAND /	DEPARTMEN ERTIFICAT				MENTAI	REG. NO			
1. DECEDENT'S NAME (First, Middle, Last							2. DATE MONTH	OF DEATH	AY,	YEAR	3. TIME OF DEATH
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216-44-9468 So. FACILITY NAME (If not institution, give	1 5/4 2 0 F	2 F F YRS. MONTHS DAYS HOUR			HOURS	MIN.	12-6-12			Count	YLAND
ANNE ARUNDEL ME									RUNDEL		
10e. STATE 10b. COUN		FET	A NINA DO		ION						10d. INSIDE CITY LIMITS? 1 X XYES 2 NO
10e. STREET AND NUMBER	E ARUNDEL		ANNAPO:		. ZIP CODI	E			10g. CIT	IZEN OF A	WHAT COUNTRY?
3 HICKS AVENUE					214	01			U	SA	
11. MARITAL STATUS 1 Never Merried 2 Nameried 3 Widowed 4 Divorced	12. WAS DECEDEN	YES 2 VW	MED 13	If yes, spe	ENDENT Coocify Cube	n, Mexica	an, Puerto I	? (Specify Ye	1	14. RACI Blac	E — American Indian, k, White, etc.
15. DECEDENT'S ED (Specify only highest grade Elementary/Secondary (0-12)		·) (Gh	CEDENT'S USUAL ve kind of work don Do NOT use retired	OCCUPATIO e during mos	ON st of workin	ng	16b	KIND OF BU	SINESS/IN		
17. FATHER'S NAME (First, Middle, Last)					18. MOTI	HER'S NA	AME (First, I	Aiddle, Meiden	Surname)		
JOHN LANE					J	OSE	PHINE	COLL	INS	100	
19e. INFORMANT'S NAME (Type/Print)			, MAILING ADDRE					110000			
CATHERINE LANE			HICKS			INAPO	DLIS,	7	CATION -		num Chata
1 Donation 5 Other (Specify)	movel from State				ITTO OF				-		AMIL OWN
III 4 - Doriettoti 3 - Other (Specify) -			matory or other place		יז מי	7.	- 1	A A NTI	TADAT		MD
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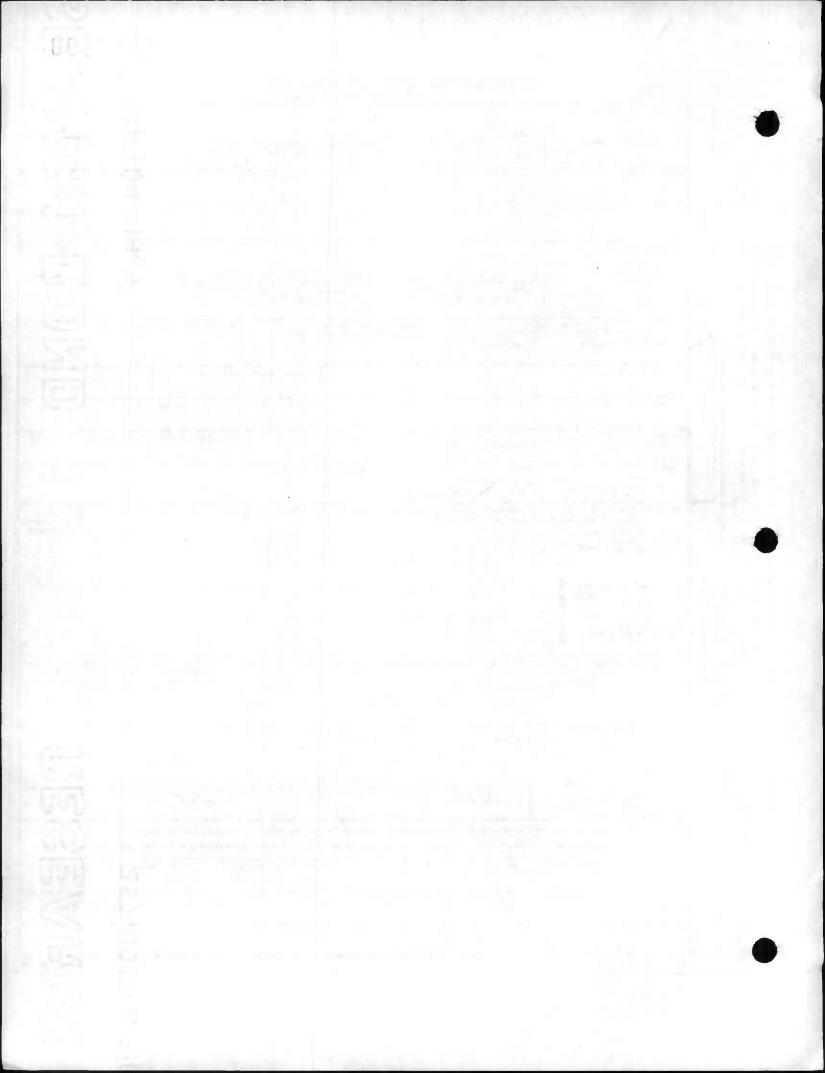
cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A CON	NSEDUENCE OF):				
PART II. Other algnificant condition	e contributing to death but no	ot resulting in ti	ne underlying ceuse given	in Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 XNQ	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL			00 00 00 00 00 00 00 00 00 00 00 00 00			
EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient		26. PLACE OF DEATH (THER: Nursing Home 5 Passidence			
27. MANNER OF DEATN 1 Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF UNDURY AT WORK? M 1 YES 2 NO				ESCRIBE NOW INJURY OCCU	JRED
3 Suicide 6 Could not be determined	28e. PLACE DF INJURY — A building, etc. (Specify)	t home, farm, stree	CATION (Street and Number of y or Town, State)	or Rural Route Number,		

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30. MAME AND ADDRESS OF PERSON WHID COMPLETED CAUSE OF DEATH (TIEM 27) (Type, Print)	Fonest da.	anaporis	21405

31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

DHMH-16 Flev 1/89



r attending physician. use as the bunal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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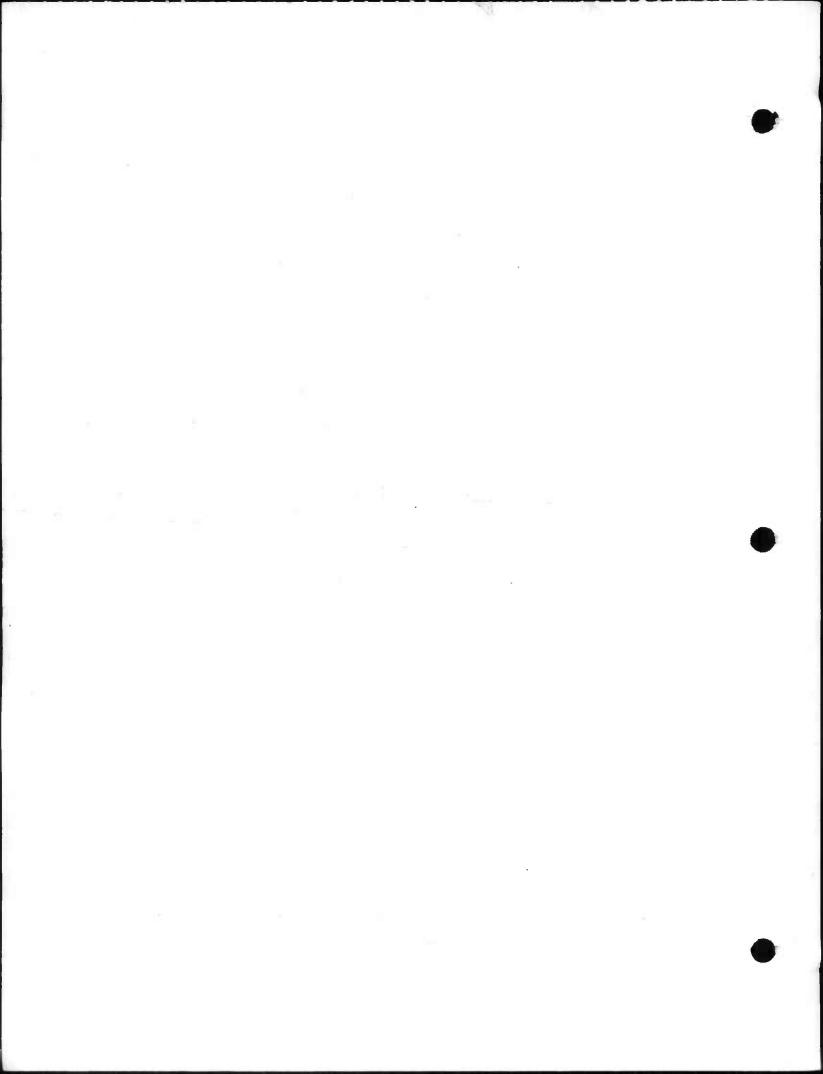
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examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
e funeral director, page 5 should be detached for al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
death. Page 6 may be retained by the hospital or	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exclours after death. Page 6 may be retained by the hospital or

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.												
	1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH									3. TIME OF DEATH			
	Khaela Charles Lollis								November 13 199		994	2:25 P M	
	4. SOCIAL SECURITY NUMBER None	5. SEX	6. AGE (In yrs. lest	birthday) YRS.	IF UNDER	DAYS	HOURS	24 HRS. MIN.	7. DATE ((Month, NOV .	Day, Year)	994	Countr	IPLACE (State or Foreign y)
	9a. FACILITY NAME (If not institution, give	and the same of th			9b. CITY	r, TOWN C	R LOCATIO	ON OF DE				INTY OF D	-
5	Holy Cross Ho	ospital			S	ilve	r Sp	ring			Мо	ntgor	mery
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY		10c. CIT	Y, TOWN (OR LOCAT	CATION						10d, INSIDE CITY
DIRECTOR		nce Georg	e George's Hya										LIMITS?
FUNERAL	104. STREET AND NUMBER 104. ZIP CODE								N/ / T		WHAT COUNTRY?		
뵘	6001 Queens Chapel Road 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMI			ED	20782				IC OBIONE	U.S.A.			
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Maxican, Puerto Rican, atc. 1 ☐ YES 2 ☒ NO Specify;					Yea or No- 14. RACE — American Indian, Black, White, atc. Specify: Black		fy:
	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	18a. DEC	EDENT'S	USUAL O	CCUPATIO	on st of workin	a	16b.	KIND OF BUS	INESS/INI		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5		Do NOT u	se retired.) No		or or worner	•			Non		
MO	17. FATHER'S NAME (First, Middle, Last)						18 MOTE	IFR'S NAM	ME (First M	iddle, Maiden			
BE C	Keith Lollis									ie Ch	,	S	
10 8	19a. INFORMANT'S NAME (Type/Print)									w, City or Town			
	Kirsten Marie Ch							l Roa					20782
ļ	20a. METHOD OF DISPOSITION 1	moval from Stata	20b. PLACE AP	AND DATE OF DISPOSITION (Name of amelory or other place) Comfort Crematory 11/20 Alexandria, VA									
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	Trounc	COM	22.	NAME AN	D ADDRES	S OF FAC	YTIJK				
	· Leinen) Sin	mon	2	Jo Av	osepl venu	h Gav	vler' V Was	s So Shing	ns, I	nc. D.C.	5130 2001	Wisconsin 16
	23. PART I. Enter the diseesea, or shock, or heart fallura	complications the	t ceused the dea	th. Do	not enter	tha mo	da of dyi	ng, such	as cerdi	ac or reapi	ratory ar	rest,	Approximeta
	shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) a. Respiratory Insufficiency												
	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate Premature 21-22 Weeks Girl OUE TO (OR AS A CONSEQUENCE OF):												
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
	that initiated events resulting in death) LAST	OUE TO	(OR AS A CONSEOU	JENCE O	F):								
B		d											
DICAL	PART II. Other significent condition	ons contributing to	death but not re-	sulting	in the un	nderlying	ceuse g	iven in F	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă									_	1 TYES 2	NO NO		OF DEATH?
PHYSICIAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VUNCERTAIN								1 Tes 2 No				
N N	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA	26. PLACE	_			UNC	EKIAIN	ıul	_			
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpetlant 3	DOA	OTHER 4 Num		5 ∏ Re	aldence 8	B 🗆 Other	(Specify)			
훉	27. MANNER OF DEATH	28s. DATE OF (Month, D	INJURY	28b. TIM		28c. INJU	JRY AT	_		RIBE HOW IN	JURY OC	CUREO	
BY	1 X Natural 5 Pending 2 Accident Investigation			1145	M	1 🗌 Y	ES 2	NO					
	3 Suicide 4 Homicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)						oute Number,						
COMPLETED	29a. CERTIFIER (Check only one) 1												
TO BE	Jalin Ol	we	M.D.				D3	1315	j			l-13-	
	30. NAME AND ADDRESS OF PERSON W							_	_				
	Fabio Olarte, M.	D. 1500 F	orest Gl	en I	Blvd.	Sil	ver	Spri	ng,	MD 209	910		
	31. Date filed (Month Gray Year) 8 1994 32. REGISTART'S Sprinary Randelle												



BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within a view fact fleath. Page 6 may be retained by the intending physician. Scattlicate has been stoned by the attending physician and completely filled in by the tuneral director, page 5, should be described for use as the burial-transit narmin. Pages 1, 2, should	in, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the middle of the may be retained by the hospital or attending physician.	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burfal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF GEATH		3. TIME OF GEATH				
	Virginia May Lemley	Lemley			November 28, 1994 11:12 PM					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthde		IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign Country) Morgantown,				
	233-72-4050 1 □ M 2 🖾 F 85 YAS	S. MONTHS DAYS	HOURS MIN.	(Month, Day, Year) May 3, 1909	W	est Virginia				
						OF OEATH				
5	Shady Grove Adventist Hospital	Rockvil	le		Montgome	ery County				
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. (CITY, TOWN OR LOCAT	ION			10d. INSIDE CITY				
DIRECTOR	Maryland Montgomery County C	Caithersburg	100			LIMITS?				
	100. STREET AND NUMBER 101. ZIP CODE				10g. CITIZEN	OF WHAT COUNTRY?				
FUNERAL	407 Russell Avenue #508		20877		United of Ame	States				
J.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO			ORIGIN? (Specify Yes	or No.— 14	RACE — American Indian, Black, White, etc.				
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	1 TES	2 NO Specify:	Puarto Hican, atc.)	L L	Specify:				
	15. DECEDENT'S EDUCATION 16a. DECEDEN	T'S USUAL OCCUPATION	M.	18b. KINO OF BUS	INCO (NICIONALICA	White				
ETE	(Specify only highest grade completed) (Give kind	of work done during mo. T use retired.)		ISD. KING OF BOS	INESS/INOUS I	NT				
4PL	12 Homema	iker		Own Ho	me					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18, MOTHER'S NAME	(First, Middle, Maiden	Surname)					
BE (Grove E. Laishley		Laura Rey	ylea						
0		ING ADDRESS (Street e								
	The survey of th	B Demain Ave								
	1 🕅 Buriel 2 🗆 Cremation 3 🗆 Removal from Stata cemetery, crematory of	TE OF DISPOSITION (Na or other place)		112/1	CATION — City					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690	11s Memoria	D ADDRESS OF FACIL		intown, I	West Virginia				
	• 4/ \	Hastin	gs Funeral H	Home, Inc	141 . 1					
	23 PART I Enter the disease of application to the				-	Virginia 26505				
	 PART I. Enter the diseases, or complications that caused the death. Dishock, or heart feliure. List only one cause on each line. 	o not enter the mo	de of dying, such a	es cardisc or respi	ratory errest,	Interval Between				
- 1	iMMEDIATE CAUSE (Finel disease or condition	i. C.	tio.			Onset and Desth				
-	disease or condition resulting in death) s. Myo cardial in farction oue-to (or as a consequence or):									
ž	Sequentially list conditions, b. Arterioscler	otic k	teart 1	DISCAS	P	54800				
Ĕ	If any, leading to immediate cause. Enter UNDERLYING	E OF):								
임	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE	OF:								
CERTIFICATION	reaulting in deeth) LAST									
	DADT II Other significant and distance and the standard at the									
SAL	PART II. Other significent conditions contributing to death but not resulting	ng in the underlying	ceuse given in Pa	PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
	Dementia			_ 1 _ YES 2	NO	OF DEATH?				
Σ	DID TORACCO LISE CONTRIBUTE TO CALLSE OF DEATH	VEC EL NO E	101000000	- '		1 TES 2 NO				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL 25. PLACE OF DI	YES LI NO K	UNCERTAIN							
Sic	EXAMINER? 1 YES 2 NO 1 Supportant 2 ER/Outpottent 3 DOA	OTHER:	5 Residence 8	Other (Specific)						
ξ	ED									
BY F	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation		×-3							
	3 Suicide s Could not be 28e. PLACE OF INJURY — At home, term	m, streat, factory, office	2	St. LOCATION (Street a. City or Town, State)	nd Number or R	tural Route Number,				
4 Homicide determined										
APL	29a. CERTIFIER (Check only one)									
one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(s) and menner at										
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year)										
6	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (7)		072	31	1101	v 29, 1994				
	James R. Moors Jr. 207 Bronke		Saither	sburgn	hD 2	h877				
1	NOV 3 0 1994									

